S. HRG. 99-601

NOMINATION

HEARING

BEFORE THE

COMMITTEE ON LABOR AND HUMAN RESOURCES UNITED STATES SENATE

NINETY-NINTH CONGRESS

FIRST SESSION

ON

ADDITIONAL CONSIDERATION OF DR. OTIS R. BOWEN, OF INDIANA, TO BE SECRETARY OF HEALTH AND HUMAN SERVICES

DECEMBER 11, 1985

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NOMINATION

WEDNESDAY, DECEMBER 11, 1985

U.S. SENATE,
COMMITTEE ON LABOR AND HUMAN RESOURCES,
Washington, DC.

The committee met, pursuant to notice, at 3:03 p.m., in room SD-430, Dirksen Senate Office Building. Senator Orrin G. Hatch (chairman) presiding.

Present: Senators Hatch, Quayle, Simon, Kennedy, Nickles, Dodd, Pell, and Kerry.

OPENING STATEMENT OF SENATOR HATCH

The CHAIRMAN. If we can, let us have order.

It is my pleasure to chair this hearing which I scheduled in order to give my colleagues and myself an opportunity to get to know the administration's nominee to become the next Secretary of Health and Human Services. His name is Dr. Otis Bowen, the former Governor of the State of Indiana, a family physician, and a gentleman who has devoted his life to serving other people. I am really pleased to welcome you, Dr. Bowen, to this committee.

Dr. BOWEN. Thank you, Senator.

The CHAIRMAN. It is an honor for us to have you here and we look forward to learning of your plans to lead the world's largest governmental agency. It is a tremendous opportunity and a tremendous responsibility.

And we all know that the Health and Human Services Department has become a huge and complex agency. And it is astonishing to realize that the amount of money spent by our Government for Health and Human Service programs exceeds the budgets of all 50 States combined. That is how much it is. And I might add that it is larger than the budgets of every other nation, save the United States and the Soviet Union.

Over the years we have definitely "put our moneys where our mouths are." When it comes to providing for the elderly, when it comes to providing for the disadvantaged and the handicapped, this Nation takes second seat to none. But the price tag for our social consciousness has become a far greater burden than many anticipated when many of these programs were enacted into law. And this growing economic burden will make this particular job of Secretary of HHS a far greater challenge than ever before. Unfortunately, as our spending for these programs has increased, our problems have not gone away and we have had difficulty raising the moneys. It seems as though the demand for services and the com-

plexity of the social issues that need addressing have increased at a faster rate than even Federal spending has.

Therefore, I believe we are particularly fortunate that you are willing to serve, one who has a wealth of experience in caring for others as a physician, who has a proven record as an effective manager and an effective leader, and who has an in-depth understanding of the complex issues related to Federal funding of health programs.

In addition to having firsthand experience as a politician, serving as speaker of the State house of representatives and a two-term Governor of the State of Indiana, Dr. Bowen was also designated by President Reagan to chair the Advisory Council on Social Security. That recent experience gave him an opportunity to gain a unique understanding of our Medicare program, which is a major focus of debate in this particular area at present.

In addition to the prerequisites of intellectual and administrative skills, I believe Dr. Bowen will be able to provide wise counsel to the administration in human terms, which after all, in my opinion, is the most important when difficult decisions have to be made.

I want to personally congratulate and thank Mrs. Heckler for the tremendous job she has done at Health and Human Services. I do not think she has received the credit that is due her. Dr. Bowen, you have, in my opinion, big shoes to fill but I know that you will be able to do so, and I know that Margaret will go on to become a marvelous Ambassador to the country of Ireland, a country that is very, very close to all of our hearts and one that I think is very important in the scheme of world events.

So, I want to pay tribute to Mrs. Heckler. But as all things change, so do the administrations at various Cabinet level Departments, and that is changing here today. And I just do not think that the administration could have picked a better person from all that I have looked at and all that I have studied and all I know about you.

We are deeply honored today to have a fellow member of this committee, Senator Quayle, who is a high ranking member of this committee and who has played a really significant role during the years that he has served on this committee. He is very close to me and I think to everybody on this committee. He has worked in a bipartisan way, he is very influential, and I think it is a great tribute to you that he is sitting there beside you.

I also want to welcome you, Mrs. Bowen, to our committee. We are happy to introduce you to everybody here, and we appreciate you coming and we hope this will be a pleasant experience for you.

So with that, if I could, I would put a statement by Senator Thurmond into the record since Senator Goldwater's wife died, he has been doing a number of the duties for Senator Goldwater and doing a good job.

[The prepared statement of Senator Thurmond follows:]

STATEMENT BY SENATOR STROM THURMOND (R-S.C.) BEFORE THE SENATE LABOR AND HUMAN RESOURCES COMMITTEE REFERENCE THE NOMINATION OF OTIS R. BOWEN TO BE SECRETARY OF HEALTH AND HUMAN SERVICES, SD-430, DECEMBER 11, 1985, 3:00 P.M.

MR. CHAIRMAN:

I commend President Reagan for his nomination of Dr. Otis Bowen to be Secretary of Health and Human Services. This is an extremely demanding Cabinet position, and I believe that Dr. Bowen is highly qualified to meet the challenges of that office.

As a former State legislator and Governor, he will have the ability to be sensitive to the concerns of State and local governments in their relationships with the Department of Health and Human Services. I am also confident that his experience as Governor of Indiana will make him an effective administrator. Furthermore, as a family doctor he has accumulated vast practical knowledge of our National health needs. In summary, I believe that Dr. Bowen will combine compassion with practicality. It is in the best interest of the Department of Health and Human Services that the Secretary possess both these important qualities.

Therefore, I urge the speedy confirmation of Dr. Bowen, and welcome him to our Committee.

The CHAIRMAN. At this point, let us turn the time over to Senator Quayle.

STATEMENT OF HON. DAN QUAYLE, A U.S. SENATOR FROM THE STATE OF INDIANA

Senator QUAYLE. Well, thank you very much, Mr. Chairman.

And I just want to tell you that even though we have had a very good working relationship with the past two Secretaries of HHS, you and this committee, of which I am a member, we are in for a real treat in getting the opportunity to work with Doc Bowen as the new Secretary.

I have known him, worked for him. I have worked with him for a number of years in Indiana. As you pointed out in your statement, his background is rather unique for this office. But he did just a tremendous and an outstanding job as speaker of the house of representatives. He did a tremendous and outstanding job as the Governor of our State. As you referred to, he was chairman of that very delicate bipartisan task force on the Medicare reform, Medicare, one of the more pressing issues that we have had. He is a country doctor from Bremen, IN, a small town. But the kind of medicine that he practiced on his patients, that he practiced on the people of Indiana for a number of years will be the type of approach that he will take in working with us and giving the entire country a very respected and blessed leadership in a very important job.

It is, in my opinion, probably the third toughest job in this town. The toughest job is being President; the second toughest job is probably being the Secretary of Defense in the Department of Defense; and the third toughest job is being the Secretary of HHS; and the fourth toughest job is your job. [Laughter.]

The CHAIRMAN. He has that in perspective, I will tell you. [Laughter.]

Senator QUAYLE. I thought I would point that out for the record that this is not an easy type of situation that we find ourselves in.

The CHAIRMAN. You build them smart in Indiana, you know. [Laughter.]

Senator QUAYLE. And the more that the Governor is in town, the more he deals with our committee and things like that, he will realize what a tough job you really have. [Laughter.]

But I am delighted that he is here before the Labor and Human Resources Committee. We do have a tremendous interest in what HHS does, particularly the jurisdiction in the health area, being the authorizing committee, and notwithstanding some of the Social Security and Medicare which are important in our Finance Committee jurisdiction.

But Doc Bowen will meet this job as he has met other jobs and it will be head on. I have said time and time again this man does not have any hidden agenda. He will tell you exactly like it is. He will shoot straight with you, square with you. He will lay out the facts as he sees it. He will give you his opinion. He will give the President his opinion. He will give the people of this country his opinion. He has been what I call very result oriented.

He has had tremendous results in our State in public office leadership positions, being speaker of the house and the Governor for 8 years. The results that he will achieve as the Secretary of HHS will also be complementary to a fine distinguished past career.

So, it is a great honor for me to be here with a friend, a trusted and respected leader in our State, and a trusted and respected leader of this country. I tell you he did not seek this job. We sought it for him. But he will take this challenge like he has taken other challenges and will do a darn, darn good job.

And I hope that the committee will be able to act with dispatch. I know the hearing this afternoon will ask some questions. I am going to go and sit on the other side of the table for awhile. But I just thank you, Mr. Chairman. The two of you will get along famously. I know both of you, and I really look forward to working with Governor Bowen when he is confirmed, I hope unanimously, by the Senate within a very short period of time.

Thank you very much.

[The prepared statement of Senator Quayle follows:]

STATEMENT OF U.S. SENATOR DAN QUAYLE (R-IN)
BEFORE THE SENATE COMMITTEE ON LABOR AND HUMAN RESOURCES
ON THE NOMINATION OF FORMER INDIANA GOVERNOR OTIS R. BOWEN, M.D.,
TO BE SECRETARY OF THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
DECEMBER 11, 1985

It is with a great deal of personal pleasure and pride that I introduce to my colleagues on this Committee today one of Indiana's favorite sons, former Indiana Governor Otis R. "Doc" Bowen, M.D., who has been nominated by President Reagan to be the Secretary of the U.S. Department of Health and Human Services.

When the White House announced his nomination, Doc Bowen was described as a "triple crown" nominee. I could not agree more. Governor Bowen is uniquely qualified for this demanding post by virtue of his political experience, his demonstrated administrative competence and his expertise as a physician.

The jurisdiction of the Senate Labor and Human Resources Committee includes a wide range of health issues. Ours is the authorizing committee for the National Institutes of Health, the

Nation's biomedical and behavioral research arm, and for the alcohol, drug abuse and mental health block grant, health manpower, community health centers and family planning. We are also responsible for oversight of the myriad issues under the purview of the Food and Drug Administration. I fully expect that, given his experience, competence and expertise, Doc Bowen as Secretary of Health and Human Services will do much to add to our Committee's debate and deliberation on all of these important subjects.

I am confident that Doc Bowen will be able to meet successfully the rigorous challenges presented by this position. The administrative problems and politically sensitive issues that the Secretary of Health and Human Services must face on a daily basis are awesome, and I am convinced that Governor Bowen is one of the very few individuals capable of taking on a task of such magnitude.

Doc Bowen has shown great skill as both a political leader and administrator throughout his career, which has included 14 years in the Indiana General Assembly, where he was Speaker of the House for six years, and two distinguished terms as Governor of Indiana. By virtue of his record as chief executive of the Hoosier State over an eight-year period, Governor Bowen remains today one of the most popular public servants in the history of Indiana.

[MORE]

Doc Bowen has been a practicing physician for 44 years, including 26 years as a family doctor in his home town of Bremen. He has regularly contributed articles to medical journals, and most recently he has been Lester D. Bibler Professor of Family Medicine and Director of Family Practice Education at the Indiana University School of Medicine in Indianapolis. As Chairman of President Reagan's Advisory Council on Social Security, he demonstrated his knowledge of the problems confronting the federal Medicare and Medicaid programs, which he will be charged with administering as Secretary of Health and Human Services. In addition, Governor Bowen showed his ability to devise innovative and successful solutions to the problem of escalating health-care costs when he worked with the Indiana General Assembly in 1975 to enact a law to curb medical malpractice costs that has been used as a model by a number of States.

I am hopeful that Doc Bowen's expertise in this area will assist this Committee's work in addressing the malpractice issue in the months ahead.

When confirmed, Doc Bowen will become the first physician to head the federal agency that has such enormous influence over health policy in this country. I believe that his medical background and his reputation in the medical community make him ideally suited to lead the Department of Health and Human Services during a time that is one of the most turbulent the health care industry has ever known in our country.

I believe President Reagan chose Doc Bowen because he is the best person for the job. It's that simple. There is no doubt in my mind that time will prove that the President was right. I urge my colleagues to support the President's nominee.

The CHAIRMAN. Thank you, Senator Quayle.

I think it speaks well for you, Dr. Bowen, to have Senator Quayle so strongly behind you. We are happy to have Senator Quayle lead out in this matter, and I hope he will come up here and sit with me.

Dr. Bowen, if you have any summary of remarks to make, we would be happy to hear from you at this time, and then we will have some questions for you.

STATEMENT OF DR. OTIS BOWEN, NOMINEE TO BE SECRETARY, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Dr. BOWEN. I do have a brief opening statement, Senator.

The CHAIRMAN. Sure.

Dr. BOWEN. First, thank you Senator Quayle, for your kind remarks, and Mr. Chairman, thank you also for your kind remarks.

Mr. Chairman and members of the committee, it is an honor to appear before you as President Reagan's nominee to be Secretary of the Department of Health and Human Services.

I am mindful of the challenging task which does lie ahead if I am confirmed by the Senate. Nearly all of you, in our initial visits, have emphasized the fact that the broad range of nearly 350 separate programs at HHS are among the most important activities of the Federal Government. To help ensure that these programs and services are managed effectively and efficiently, I will immediately recruit the most able and competent individuals to fill the key vacancies which currently exist at the Department. I will also seek your guidance and your counsel and cooperation as I set out to manage the Department and guide its policies.

In addition to the major programs which provide income support and medical care coverage for the elderly, disabled, and the poor, I will devote a great deal of personal interest and attention to the programs which support research into the causes of disease; promote preventive health measures; support the provision of health and social services; combat alcoholism and drug abuse, and guard against unsafe drugs and contaminated foods, as well as other key programs.

I am aware of the significant number of programs which your committee authorizes and oversees within the jurisdiction of HHS. A good working relationship between us is essential to the success of these programs. Toward that end, I do pledge my efforts.

Our critical challenge is to be sensitive to the needs of the beneficiaries, the providers, and the taxpayers. In a larger sense, we must balance these needs while retaining quality and restraining cost. Once that balance has been struck, with unity of purpose and honesty of communication, we will most effectively ensure that Americans will have access to the services that we provide.

And I welcome, with God's help, this challenge.

Mr. Chairman, I will be happy to respond to questions.

[The prepared statement of Dr. Bowen and responses to questions submitted to him by members of the committee follow:]

STATEMENT OF GOVERNOR OTIS R. BOWEN, M.D.

Mr. Chairman and Members of the Committee, it is an honor to appear before you as President Reagan's nominee to be Secretary of the Department of Health and Human Services.

I am mindful of the challenging task which lies ahead if I am confirmed by the Senate. Nearly all of you, in our initial visits, have emphasized the fact that the broad range of nearly 350 separate programs at HHS are among the most important activities of the Federal government. To help insure that these programs and services are managed effectively and efficiently, I will immediately recruit the most able and competent individuals to fill the key vacancies which currently exist at the Department. I will also seek your guidance and cooperation as I set out to manage the Department and guide its policies.

In addition to the major programs which provide income support and medical care coverage for the elderly, disabled, and the poor, I will devote a great deal of personal interest and attention to the programs which support research into the causes of diseases; promote preventive health measures; support the provision of health and social services; combat alcoholism and drug abuse and guard against unsafe drugs and contaminated foods as well as other key programs.

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I welcome this challenge.

Mr. Chairman, I am happy to respond to your questions.

CURRICULUM VITAE
OTIS R. BOWEN, M.D.

CURRENT POSITION	Lester D. Bibler Professor of Family Medicine and Director, Undergraduate Family Practice Education
BUSINESS ADDRESS	Department of Family Medicine Indiana University School of Medicine 1100 West Michigan Street Indianapolis, IN. 46223 (317) 264-4971
DATE OF BIRTH	February 26, 1918
PLACE OF BIRTH	Richland Center, Indiana
MARITAL STATUS	Married, February 25, 1939 formerly Elizabeth Ann Steinmann (deceased 1/1/81) Children: Richard H. Bowen, Judith I. McGrew, Timothy R. Bowen, and Robert O. Bowen Married, September 26, 1981 formerly Rose May Hochstetler
RELIGION	Lutheran (St. Paul's Lutheran Church, Bremen, In. and Pleasant View Lutheran Church, Indianapolis, In.
EDUCATION	Indiana University, Bloomington, Indiana A.B. Degree in Chemistry - 1939. Indiana University School of Medicine, Indianapolis, IN. M.D. Degree - 1942. Rotating Internship, Memorial Hospital South Bend, Indiana, 1942 - 1943.
ARMED SERVICE	United States Army Medical Corps, Pacific Theatre, World War II, 1943 - 1946.
POLITICAL, GOVERNMENTAL POSITIONS	Coroner, Marshall County, Indiana, 1952 - 1956. Indiana House of Representatives, Republican Member, 1957, 1958, 1961 - 1972; Minority Leader, 1965 - 1966; Speaker (three terms), 1967 - 1972. Legislative Council; Indiana General Assembly: Vice Chairman, 1967 - 1968; 1969 and 1971; Chairman, 1970 and 1972. Delegate, Republican National Convention, 1972 and 1976. Governor, State of Indiana, (two terms) 1973 - 1981.

GOVERNMENTAL AFFILIATIONS

Past

Chairman, Advisory Council on Social Security 8/1982 to 12/1984. (President Ronald Reagan).
Member, Advisory Council, United Student Aid Fund.
Member, Two Year Study of Nursing and Nursing Education, Institute of Medicine, National Academy of Sciences, 2/1981 to 2/1983.
Member, Presidential Advisory Committee on Federalism, 4/1981 to 12/1982 (President Ronald Reagan).
Republican Governor's Association, Member, 1973-1981; Chairman, 1978-1979.
Chairman, Midwest Governor's Conference, 1973-1979.
Education Commission of the States, Member, 1973-1981; Chairman, 1977-1978.
Executive Committee, Council of State Governments, Member, 1973-1981.
National Governor's Association, Member, 1973-1981; Committee Member, 1972-1978; Chairman, 1978-1979.
Midwest Governor's Great Lakes Caucus, Member, 1973-1981.
Advisory Commission on Intergovernmental Relations, Member, 1977-1979, (President Gerald R. Ford).
Interstate Mining Compact Commission, Chairman, 1978.
National Governor's Association, Committee on Crime Reduction and Public Safety, Chairman, 1973-1978.
President's Committee on Science and Technology, Member, 1976-1977, (President Gerald R. Ford).
Commission on Federal Paperwork, Member, 1975-1977, (President Gerald R. Ford).

Present

Member, Senator Lugar's Federal Judicial Appointments Commission, 1981 to present.
Board of Directors and Subscribing Member, Hoosier Celebration '88, Inc. (with Governor Robert D. Orr and former Governor Matthew E. Welsh). An Indiana not-for-profit corporation organized for the purpose of promoting Indiana, to increase community pride and to engage in constructive planning for economic opportunities for Indiana and its residents.

GOVERNING ROLES:
EDUCATIONAL, CIVIC
AND PRIVATE
INSTITUTIONS

Past

Member, Board of Trustees, Valparaiso University, 1978 to 10/1984.
Member, Board of Directors, Indiana Science Education Fund, to 11/1984.
Member, Advisory Committee, Vincennes University.
Member, Board of Directors, Center for Public Service, Anderson College (Honorary).
Member, Board of Trustees, Ancilla College, 1970 to 1976.
Member, Board of Directors, Greater Indianapolis Council on Alcoholism, Inc./NCA, 9/1982 to 10/1984. (on non-active status).
Member, Advisory Board, Indianapolis Chapter, Fellowship of Christian Athletes.
Member, Board of Directors, United States Track and Field Hall of Fame, Inc. to 5/1984.
1982 Christmas Gift Chairman, Mental Health Association of Indiana Inc.
Chairman, Cancer Crusade, American Cancer Society, Indiana Division, 1981-1982.
Honorary Chairman, American Red Cross, Indianapolis Area Chapter, African Relief Campaign, 12/1984 to 5/1985.
Member, Board of Visitors, School of Public and Environmental Affairs, Indiana University, 8/1982 to 6/1985.
Member, Board of Directors, BetaMED Pharmaceuticals, Inc., 10/1982 to 2/1985.
Member, Board of Directors, Hook Drugs, Inc., 2/1981 to 5/1985.
Member, Board of Directors, On Farm Computing, Inc., 11/1981 to 6/1985.
Member, Indiana State Medical Association, Committee on Medical Malpractice, 3/1982 to 12/1984.
Member, Board of Directors, Fairbanks Hospital Inc., Indianapolis, In. 8/1983 to 3/1984.

Present

Member, Board of Directors, Ivy Tech Foundation.
Chairman, Advisory Council, BACCHUS, 1979 to present.
Member and Past Chairman, Board of Governors, Woodburn Guild, Indiana University Alumni Association, 8/1981 to present.

GOVERNING ROLES:
continued

Present

Member, Board of Governors, Riley Memorial Association, 2/1981 to present.
Member, Board of Directors, Indiana Neuromuscular Research Laboratory, 3/1981 to present.
Member, Advisory Council, Indiana Cardinal Society, 1980 to present.
Member, Board of Directors (ex-officio), Family Support Center, Inc. 6/1981 to present.
Member, Advisory Council, Chemical Independent Children, Inc., 1982 to present.
Honorary Member, Board of Governors, Associated Colleges of Indiana, current.
Member, Board of Trustees, Leukemia Society, Indiana Chapter, 7/1981 to present.
Member, Board of Directors, Indiana State Chamber of Commerce, 1981 to present.
Member of the Cabinet, Campaign for Indiana, Indiana University, Bloomington, 6/1984 to present.
Chairman, Indiana Future Farmers of America Foundation Sponsoring Committee, 5/1984 to present.
Member, Advisory Board - Indianapolis, Campaign for Indiana, Indiana University, 7/1985 to present.

Member, Board of Directors and Executive Committee, Lilly Endowment, 2/1981 to present.
Member, Board of Directors, First Source Bank of Bremen, 2/1981 to present.
Member, Board of Directors, Indiana National Bank, 2/1981 to present.
Member, Board of Directors, Blue Shield of Indiana, 1981 to present.
Member, Board of Directors, Meridian Mutual Life Insurance Company, 1981 to present.
Member, Board of Directors, U.S. Care Corporation, 6/1982 to present.
Member, Board of Directors, Public Service Indiana, Plainfield, In. 6/1983 to present.
Member, Board of Directors, Indiana Bell Telephone Company, 12/1983 to present.
Member, Board of Directors, Health and Hospital Corporation, Indianapolis, In. 7/1985 to present.
Editor: Lifewise Report, 1985. (A weekly report on health matters for employees: owner is Harley Bierce, 2935 North Meridian St., Indianapolis, In.
Consultant, Dalton Foundries, Warsaw, In., 1985.

DIPLOMAS, FELLOWSHIPS AND HONORARY DOCTORATES

Diplomas: Divine Heart Seminary, 1971; Kewanna High School, 1980.
Fellowship: St. Joseph College, 1979.
Doctorates: Vincennes University, 1973; Valparaiso University, 1973; Butler University, 1973; Anderson College, 1973; Indiana University, 1976; Calumet College, 1976; Tri-State University, 1976; University of Evansville, 1977; Indiana State University, 1977; Rose Hulman Institute of Technology, 1977; Ball State University, 1978; University of Notre Dame, 1978; St. Mary's College, 1978; Manchester College, 1979; Hanover College, 1981; St. Joseph College, 1981; Marian College, 1982; Purdue University, 1982; Bethel College, 1982.

HONORS AND AWARDS

"Merit Award," Indiana Public Health Association, (Highest honor bestowed on an individual for outstanding achievement in public health), 1971.
"Alumnus of the Year" Award, Indiana University School of Medicine, Alumni Association, 1971.
First recipient of AMA's "Benjamin Rush" Award for outstanding contribution by a physician in citizenship and public service, 1973.
Medal of Honor, University of Evansville, 1975.
Medal of Honor, Valparaiso University, 1976.
Valparaiso University, eight Otis R. and Elizabeth A. Bowen Scholarships established on a permanent basis, 1981.
Indiana University - School for Public and Environmental Affairs, established a Beth Bowen Scholarship, 1981.
Ancilla College, Beth and Otis Bowen Scholarship Fund, established 1981.
Bethel College, Mishawaka, Indiana, built and on March 23, 1984 dedicated the Otis R. and Elizabeth A. Bowen Library.

MEDICAL ORGANIZATIONS

Member, Marshall County Medical Society
Member, Marion County Medical Society
Member, Indiana State Medical Association
Member, American Medical Association
Member, 13th District Medical Society
Member, Indiana Academy of Family Physicians
Member, American Academy of Family Physicians

AFFILIATIONS

Kiwanis Club
Phi Beta Pi
Alpha Omega Alpha
Delth Chi
Family Practice Club, IAFP

PUBLICATIONS

Bowen, Otis R., Should Patients Be Told When the Diagnosis is Cancer?, Journal of the Indiana State Medical Association, April, 1953.

Bowen, Otis R., Why Cancer Victims Should Be Told the Truth, Medical Times, Vol. 83, No. 8, pp. 793-799, August, 1955.

Bowen, O.R., Stine, M.E., Walters, C.E., Successful Management of Burn Case Involving 45% of Body Surface, Journal of the Indiana State Medical Association, Vol. 48, No. 9, pp. 972-975, Sept. 1955.

Bowen, Otis R., A Physician Legislator Looks at Public Welfare, The Director, Publisher: Indiana State Association of County Welfare Directors, July, 1964.

Bowen, Otis R., A Physician Looks At the Public Health Profession, Journal of Milk and Food Technology, Vol. 29, No. 1, pp. 1-4, Jan. 1966.

Bowen, Otis R., Doctor! Take the Time! Make the Effort! Journal of the Indiana State Medical Association, Vol. 60, No. 9, pp. 1264-66, Sept. 1967.

Bowen, Otis R., Dr. Otis Bowen's Position, Indiana Church Councilor, Vol. LXXX, No. 4, Sept. 1972.

Bowen, Otis R., My Plan For Indiana, Michiana; Publisher: The South Bend Tribune, Jan. 7, 1973.

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Bowen, Otis R., My First Year As Governor, Michiana; Publisher: The South Bend Tribune, Dec. 15, 1973.

Bowen, Otis R., Feature Article, American Banker, June 12, 1975.

Bowen, Otis R., Interview: U.S. News and World Reports, Vol. LXXIX, No. 7, pp. 65-67, Aug. 18, 1975.

Bowen, Otis R., Indiana Report for '75 and Plans for '76, Michiana, Publisher: The South Bend Tribune, Dec. 21, 1975.

Bowen, Otis R., Guest Column for Ed Ziegner, Indianapolis News, June 16, 1976.

Bowen, Otis R., Feature Article, Indiana Home Builders News, Aug. 1976.

Bowen, Otis R., Comment, Emergency Product News, Vol. 8, No. 4, July/August, 1976.

Bowen, Otis R., Feature Article, Indiana Retail Grocer's Association, Sept. 1976.

Bowen, Otis R., Feature Article, Indiana Rural News, Sept. 16, 1976.

Bowen, Otis R., Article for the Topics Newspapers, Indianapolis, In., Oct. 6, 1976.

Bowen, Otis R., Proceedings of the Indiana Governor's Conference on Child Abuse and Neglect; Published by the State of Indiana, June 13, 1977; pp. 29-32.

Bowen, Otis R., Malpractice: A Battleground for States, The Suffolk Academy of Medicine Bulletin, Vol. 55:7, pp. 18-21, Sept. 1977.

PUBLICATIONS (cont)

Papers presented at Inservice Education Programs sponsored by Education Commission of The States (ECS) in cooperation with the State Higher Education Executive Officers (SHEEO). Three listed below:

1. Bowen, Otis R., A Governor's View of Higher Education IEP/Association of Governing Boards of Universities and Colleges, Nov. 1977, IEP Paper No. 011, p. 11, ERIC Document Reproduction Service, No. HE 013 859.

2. Bowen, Otis R., A Governor's View, IEP/Division of Eligibility and Agency Evaluation, U.S. Office of Education, July, 1978, IEP Paper No. 010, p. 11, ERIC Document Reproduction Service, No. HE 013 807.
(Also in IEP Proceedings No. 910, pp. 1-4.)

3. Bowen, Otis R., Statewide Boards for Higher Education: A Governor's View, July, 1979, IEP Paper No. 012, p. 12, ERIC Document Reproduction Service, No. ED 180 282.

Bowen, Otis R., National Health Policy: Which Direction Should the Nation Take? Prepared for the Platform Committee for the 1980 Republican National Convention, Spring, 1980.

Bowen, Otis R., My Eight Years As Governor - Satisfactions and Frustrations, The South Bend Tribune, Sunday, Jan. 4, 1981.

Bowen, Otis R., 1982 Mid-Winter Conference: Can The Practicing Physician Be A Successful Politician? North Carolina Medical Journal, Vol. 43, No. 5, pp. 360-364, May, 1982.

Bowen, Otis R., Medical Malpractice Law In Indiana, Journal of Legislation, Published by the Notre Dame Law School, Notre Dame, Indiana, Vol. 11, No. 1, pp. 15-26, Winter, 1984.

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Revised
11/85

ANSWERS TO QUESTIONS SUBMITTED BY MEMBERS OF

THE SENATE LABOR AND HUMAN RESOURCES COMMITTEE

Senator Hatch

ABORTION

QUESTION:

There have been concerns raised about your position on Federal funding for abortion services. Again, I understand that you have stated you will support President Reagan's position that no Federal funds shall be used for abortion services except to save the life of the mother. Am I correct?

ANSWER:

Yes, you are correct. Federal law currently prohibits the use of Federal funds for abortion services and I will support HHS policies that are consistent with the law.

LIVING WILLS

QUESTION:

One of the recommendations of the Medicare Commission was the endorsement of Federal legislation regarding "Living Wills." As Secretary of Health and Human Services, would you actively seek such legislation?

ANSWER:

As you are aware, the recommendations of the Commission represent a consensus of its member's views. I have no plans to seek such Federal legislation.

MALPRACTICE

Question: Dr. Bowen, as a practicing physician and respected medical educator you know that we are in the midst of a medical malpractice crisis. The frequency of malpractice claims against physicians has been steadily increasing. Claims for 1983 are estimated to be more than double the number in the mid-70's. Since the mid-70's, the average award has tripled. Today, the average verdict is almost $340,000. As a man with past experience and expertise in medical malpractice legislation at the State level, what do you see as the role of the Federal government and DHHS in this important area of concern?

Answer: The Department has in the past supported State initiatives for tort reform in the area of medical malpractice. Since tort law has traditionally been a matter of State jurisdiction, I believe that the initiative appropriately rests with the States rather than the Federal government. However, I remain open to continued discussion with all parties about what activities might constitute an appropriate Federal role.

HOME HEALTH CARE

QUESTION:

As you know, the segment of our population that is growing most rapidly is composed of elderly Americans. By the year 2010, when baby boomers begin to retire, the elderly will comprise 14% of the population, and by the year 2035, 22% of the population. Our senior citizens have unique and often complicated health problems, and often require costly care in a hospital or an extended care facility. Given the inevitable increase in demands for these services, I have championed an emphasis on home health care as a less expensive and much preferred alternative to institutional care. What do you see as the Federal government's role in home health care for the elderly?

ANSWER:

At the outset, I recognize your role and commend you for your efforts in this area. I agree that there will be an increased demand for home health services in the decades ahead and I support home health care as an alternative to institutional care. The Department's role, at this time, is to carefully evaluate the effectiveness of home health care with the goal of providing health care policymakers with the best possible information for decisionmaking. To this end, the Department continues to carry out research aimed at examining the cost-effectiveness of community-based and in-home delivery systems for long term care and developing prospective payment approaches for home health care services.

AIDS

Q: Dr. Bowen, the acquired immune deficiency syndrome (AIDS) has been declared by Secretary Heckler as the Nation's number one health priority. Indeed, I'm told that over 15,000 AIDS cases have been diagnosed in the United States to date, that this number is expected to increase, and that the AIDS problem will be with us for many years to come. Dr. Bowen, what do you see as the role of DHHS as we deal with the AIDS problem for the foreseeable future?

A: To continue HHS efforts to find effective treatments for AIDS patients and to develop a vaccine to prevent the disease. It may take some time to achieve these goals in this area. In the meantime, HHS is engaged in a major effort to educate Americans, in particular those at high risk for AIDS, about the disease and behavioral changes that can be implemented to prevent its spread. We will continue research into the epidemiology of the disease to identify factors that predispose a person to AIDS.

AIDS RESEARCH

Q: In your view has the current balance of Federal funding for basic and applied AIDS research been appropriate? If not, where should the emphasis be? In basic research? In treatment of AIDS? In prevention?

A: We believe there is a proper balance between basic, investigator initiated research and research that utilizes the findings from these basic studies and applies them to prevention and treatment efforts. The HHS funding level for AIDS has grown each year as the Department has identified opportunities for expanding its efforts against the disease. The appropriations for AIDS have grown from a level of $5.5 million in FY 1982 to $244.3 million in FY 1986. The substantial increase in the FY 86 appropriations for AIDS is for greatly expanded efforts in the testing of new drugs, treatment of patients in clinical trials, and public information education. It also calls for health care delivery service demonstration projects for victims of AIDS in those four standard metropolitan statistical areas having the highest incidence of the disease.

DEPARTMENT ROLE IN REDUCING ELDER ABUSE

QUESTION:

Some gerontologists claim that 4% of our 36 million senior citizens are abused. Other experts report that the actual figure is closer to 20% since many cses are not reported. Many of these abused victims are typically female, age 75, in poor health and lack financial resources to care for themselves. Senator Andrews and several other senators, including myself, introduced a bill yesterday to create a task force to examine the critical problem of elder abuse. What role do you see your Department playing to reduce the incidence of elder abuse

ANSWER:

The Department of Health and Human Services has for some time been playing a role that includes both research into the problem and funding of services. Under the Older Americans Act, the Administration on Aging (AoA) is responsible for collecting, publishing and disseminating information on all aspects of aging, including elder abuse. For example, in FY 1986 AoA will fund projects to demonstrate statewide collaboration among aging, protective services, mental health, and law enforcement agencies to control and prevent elder abuse. In FY 1985, AoA awarded a grant to support a national effort to make available to State and Area Agencies on Aging, practitioners, planners, policy-makers, and others, an extensive array of current information about elder abuse and efforts to combat it at State and local levels. Another example is a project to demonstrate a successful elder abuse consortium model in four sites, for possible later widespread use.

Other HHS agencies are also involved in research and demonstrations in this area. The National Institute on Aging is currently funding a two-year research project by the University of New Hampshire Family Research Laboratory on conflict and abuse in the family care of the elderly, intended to establish a prevalence rate for elder abuse and to identify factors associated with elder abuse and to construct a causal model. In addition, the National Institute of Mental Health funds projects dealing with family violence, including elder abuse.

I recognize the seriousness of this problem, and assure you that the Department will continue to use these authorities to reduce the incidence of this tragic problem.

DEVELOPMENTAL DISABILITIES

QUESTION:

In the past few years, we have seen an increase in support for programs serving handicapped individuals. As part of the National Decade of the Disabled activities, the Administration on Developmental Disabilities has sponsored a successful initiative to promote employment of developmentally disabled persons. Under your leadership, what actions do you see the Department taking to help disabled people help themselves?

ANSWER:

Handicapped persons seek lives of independence and productivity, and the Federal government plays a critical role in helping them to fulfull these aspirations. The Administration on Developmental Disabilities has worked to encourage employers to hire the disabled. These efforts have met with great success, and I intend that they will continue. In addition, the Developmental Disabilities Act of 1984 requires States to make employment services a priority by FY 1987. I intend to see that this law is fully implemented.

CIGARETTE ADVERTISING

QUESTION: Dr. Bowen, the AMA is currently seeking to totally ban advertising on cigarette smoking in this country. What are your feelings about this effort?

ANSWER: As a physician, I believe the use of tobacco for most individuals does create a health hazard. I firmly believe that the potential hazards of tobacco use should be clearly placed on the labels so that individuals can make their choice. However, I do not believe the opinion of most of the half million physicians of this country whose responsibility it is to care for the health of our people can be ignored. The whole subject of advertising on tobacco use needs to be studied and weighed, while still offering some freedom of choice.

DISEASE PREVENTION

QUESTION: Dr. Bowen, under recent Secretaries of DHHS, disease prevention has received renewed emphasis as an integral component of national health policy. As a long-term proponent of disease prevention myself, I'd be interested in learning whether this emphasis will continue under your tenure as Secretary?

ANSWER: Absolutely. As a physician, I am keenly aware of the benefits derived from preventive health measures. I feel it is incumbent upon the government to encourage such preventive measures to the maximum extent possible. The Department of Health and Human Services is the lead health agency in the Nation --indeed in the world. Its activities touch upon the lives of each and every American. A role in fostering preventive health measures is a logical and appropriate mission of the Department.

MEDICAL EDUCATION

QUESTION:

Given that we now have sufficient nnumbers of doctors in several regions of the country, what role do you feel the Federal government should play in the financing of medical education and post-graduate medical education?

ANSWER:

Because the Nation's aggregate supply of health professionals appears to be adequate, with surpluses in some areas, Federal programs, to the extent resources permit, should focus on special problems such as specialty maldistribution, geographic shortage areas, the need for additional training in the care of the elderly, and the under-representation of minorities in the health professions. Our role in this program area should continue to be limited to dealing with such problems.

As you know, I chaired the President's Advisory Council on Social Security which concluded that it was inappropriate for the Medicare program to underwrite indefinitely the costs of graduate medical education. While agreeing with the concept of reducing Federal financial support through the reimbursement programs, I realize that abrupt changes could create serious funding problems for teaching hospitals, especially hospitals serving large numbers of low-income persons and, therefore, I am sensitive to the need to reduce support in a mannor that would seek to avoid unnecessary adverse or negative effects.

RURAL HOSPITALS

Question: What steps should the Federal government take to address the financial difficulties many of our Nation's rural hospitals have reported?

Answer The Medicare prospective payment system (PPS) was established under the provisions of Public Law 98-21, the Social Security Amendments of 1983. Under this system, a hospital's payment rate is partially dependent on its urban or rural location. Section 1886(d)(2)(D) of the Social Security Act (which was added by Public Law 98-21) defines an urban area as any area within a Metropolitan Statistical Area (MSA), as defined by the Office of Management and Budget (OMB), or within such similar area as the Secretary has recognized by regulation for the hospital cost limits established by the Tax Equity and Fiscal Responsibility Act of 1982. A rural area is defined as any area outside of an MSA. The law is very clear in the requirement to distinguish between urban and rural hospitals in deriving and applying the prospective payment rates.

Although the law refers to criteria established by OMB in administering PPS, it has been suggested that an alternative means for aggregating rural counties in a way that is more reflective of economically integrated rural areas needs to be investigated. The Department has acknowledged the need for further research in this area. In this connection, I also understand that the Prospective Payment Assessment Commission is currently studying this issue.

Section 2311 of Public Law 98-369 also requires the Department of Health and Human Services (DHHS) to study and report to the Congress on the effects on rural hospitals of payments for certain diagnosis related groups (DRGs) which have high fixed nonlabor components that do not vary significantly between urban and rural areas and the advisability of varying by DRG the proportion of labor and nonlabor components of the Federal payments amount. I believe these initiatives will help to minimize the possibility that a hospital will be treated unfairly because of its geographical location.

In addition, Public Law 98-21 requires DHHS to study and report to Congress on the feasibility and impact of eliminating or phasing out separate urban and rural payment rates. Although this report will enable us to determine the extent to which changes in the urban/rural classification system are necessary and appropriate, the Department has also taken steps to address some of the more immediate concerns of rural hospitals.

These include the establishment of criteria for designating hospitals as referral centers in response to the problems of hospitals located in rural areas which offer a comprehensive range of complex services and serve as regional resources. The hospitals which qualify as rural referral centers receive payment at the appropriate urban rate.

RURAL HOSPITALS

Also, hospitals located in newly designated rural areas have been provided a 2-year phase down from the urban to rural payment rate. This provision is intended to ease the impact of the sudden shift to a significantly lower payment rate on hospitals located in those areas which were previously designated urban.

PPS also contains a special feature to protect hospitals that are the only source of care in a wide area. These hospitals, known as sole community hospitals, can qualify to receive payment based on a blended rate under which 75 percent of the rate is derived from the hospital's own historical cost and only 25 percent of the rate is based on the rural average. In these cases, most of the hospital's payment is unaffected by the urban/rural classification or area wage index. Most hospitals can receive this type of payment only for the first year of the 3-year transition to a national prospective rate. A sole community hospital can also qualify for an additional exception to cover fixed costs should its number of discharges decline as a result of circumstances beyond the hospital's control. These provisions, contained in Public Law 98-21, are specifically intended to aid hospitals which are the only providers of acute care services in their areas.

As Secretary, I will see that the Department continues to monitor the impact of PPS on rural hospitals to ensure that Medicare beneficiaries have continued access to high quality care.

TUBERCULOSIS

Q: Tuberculosis remains a major health problem throughout the world. In this country, it is again becoming a serious health problem as refugees bring in resistant strains. What steps should the Public Health Service take to eradicate this preventable disease?

A: We are confident that progress is being made in this country even though new cases of tuberculosis continue to occur with potential new problems related to AIDS, the homeless, and immigration. Nevertheless, we believe that more can be done. In our report to the Senate Committee on Appropriations, we outlined the three steps necessary to hasten the elimination of tuberculosis from the United States. These steps included 1) more effective application of existing methods for prevention and control; 2) initiation of basic and applied research efforts using modern biotechnology to develop more effective, simpler, and less expensive control methods; and 3) rapid and effective transfer of new prevention and control methods into field operations.

We are actively encouraging expanded research in tuberculosis. In collaboration with the National Institutes of Health, the American Thoracic Society, and the Pittsfield Antituberculosis Association, we cosponsored a conference in June 1985 to identify feasible new technologies that could be developed to accelerate the elimination of tuberculosis. Representatives from a variety of disciplines--biochemistry, epidemiology, immunology, microbiology, genetics, behavioral science, pulmonary medicine, public health, clinical infectious diseases, and pathology--developed an agenda for future research activities which will serve as a guide and a challenge to the entire scientific community. Much research can and must be done to develop simpler, more effective, and less expensive methods for diagnosis, treatment, and prevention. PHS agencies are renewing their commitment to stimulate this research.

We are confident that this accelerated elimination approach can be successful. However, we believe that State and local health departments should continue to have primary responsibility for establishing and funding modern tuberculosis control programs with technical help provided from the Public Health Service.

SMOKING EDUCATION

Q: Smoking is the number one preventable cause of death in the United States. The Surgeon General has called for a smoke free society by the year 2000.

What additional steps can be taken to bring about a smoke-free society?

A. The problem of smoking and its effect on health is a national one and one which cannot be solved by government alone. If our efforts are to be successful, it will require a total effort of all society, including those of government, health care, the community, and the individual. We must have programs of information, education, and where applicable, regulation. We must increase our efforts to inform all our citizens about the dangers of smoking; to persuade children not to start the habit and convince adults who smoke they must quit. History has shown however, that we have achieved considerable success in reaching our goal. Over 34 million smokers have successfully quit and fewer and fewer children are now adopting the behavior. These changes are beginning to have a sizeable benefit on the health of this nation and will continue to do so in the future.

CHILD SUPPORT ENFORCEMENT

QUESTION:

I was a strong advocate of the Child Support Enforcement legislation, which was signed into law in 1984 under Secretary Heckler's guidance. I urge you to continue taking an active and leading role in enforcing this legislation to ensure that parents who have custody of their children receive their court-awarded child support payments. Will you do that?

ANSWER

I am a strong advocate of child support enforcement and will carry forward the Administration's initiative to implement the Child Support Enforcement Amendments of 1984. I believe parents who abandon their families definitely should bear the financial burden of supporting them, regardless of whether the family is receiving welfare. The Child Support Enforcement program plays a significant role in ensuring that children receive their legally awarded child support payments. The 1984 Amendments equip the program to make major inroads in combatting the non-support problem.

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HOME HEALTH

Question: As I said earlier there is growing support for the position that home health care is cost effective. I have been informed by the home health care agencies in Rhode Island that the administrative responsibilities existing under the home health care regulations have increased their costs dramatically. For example, it costs an additional $13,000 in start up costs for any agency of 5 to respond to these additional responsibilities. The amount of time and staff necessary to respond to these administrative responsibilities on a day-to-day basis also have increased dramatically.

I would like to know whether these additional administrative responsibilities are absolutely necessary. I believe we are defeating our objective--to reduce the cost of health care generally--by increasing the administrative responsibilities and costs of home health care agencies.

Do you have any comments on this development?

Answer: Yes. I assume the question relates to implementation by the Health Care Financing Administration (HCFA) of uniform home health data forms to be used by fiscal intermediaries (FIs) in determining the necessity of services for which home health agencies (HHAs) submit claims. The forms are the HCFA 485, 486 and 487.

The data forms were developed in cooperation with representatives of HHAs and FIs to promote more uniformity among all FIs in the data they collect. This uniformity should, in turn, result in more consistent coverage decisions and minimize payment for noncovered services. The form should represent neither an additional cost nor administrative burden on HHAs. In fact, the November 1985 "Home Health Journal" (a major industry publication) contained an article on the data forms which pointed out that they are "really no different from former monthly summary forms required by most State FIs before September/1, 1985."

The HCFA-485, which is completed by the HHA and physician, contains the data required by regulation to meet the physician's plan of treatment and home health certification requirements. The data needed by FIs to make coverage determinations for home health claims are contained on the HCFA-486. If additional documentation of any elements on the HCFA-485/486 is necessary, the HCFA-487 may be used by the home health agency and/or physician. These are the only medical information forms that the FI can require to be submitted with the claims; all other home health forms are obsolete. We have, therefore, limited the number of different forms the FIs can require home health agencies to send with their claims.

In summary, let me reiterate that the home health forms will result in more consistent administration of the benefit, more correct decisions, and should impose little additional burden on the HHA.

QUALITY OF CARE UNDER PROSPECTIVE PAYMENT

Senator Kerry

Question: Despite the significant savings to the Medicare program as a result of the Prospective Payment System, serious concerns remain about patients, especially the frail elderly, who are being discharged prematurely, and then less than adequate Medicare coverage is provided for the necessary home-care services. How would you respond to these growing concerns that the DRG payment system has caused a decline in quality of care for the elderly? How would you propose to respond to hospitals denying care to patients who will need costly services?

Answer: Your question covers four concerns. I will respond to them in the order you raised them. First, the concern of premature discharge.

- The Medicare program emphasizes that Medicare beneficiaries should stay in the hospital as long as medically necessary. Medicare does not decide how long a patient should remain in the hospital; the patient and the patient's physician decide when hospitalization is necessary and how long a patient should remain in the hospital.

- Hospital care provided to Medicare patients is reviewed by physician groups called Utilization and Quality Control Peer Review Organizations (PROs). The Health Care Financing Administration (HCFA) contracts with PROs to assure that the care provided to Medicare patients is medically necessary, reasonable, rendered in the appropriate setting, and is of good quality. PROs are constantly monitoring hospitals to assure that Medicare patients are receiving all the hospital care they need, that Medicare patients are not denied admission when they need to be in the hospital, and that hospitals are deterred from discharging patients before they are well enough to be released. They conduct review to detect premature discharges, unnecessary readmissions, and other practices which are potentially harmful to Medicare patients. When PROs find these harmful practices, they are required to take corrective actions ranging from education of the aberrant hospital or physician to possible exclusion of the hospital from the Medicare program.

Your second concern related to the adequacy of home health services under the Medicare program. In that regard:

- The Medicare home health benefit was always intended to complement an inpatient hospital stay. The requirement that the patient need skilled nursing care or physical or speech therapy shows how the benefit is focused on patients recovering from an acute illness. Medicare has never covered general housekeeping services or other home care services furnished mainly to assist people in meeting personal family or domestic needs. Medicare presents a continuum of care designed to care for the patient at each level of need. Thus, the skilled nursing care and home health benefits are designed to care for the patient on discharge from the hospital.

- We are proposing changes to the Hospital Conditions of Participation which will strengthen and clarify discharge planning requirements. We will specify that patients must be transferred to appropriate health care services for followup care.

- Although PROs are not required to monitor patients' continuum of care, the new Scope of Work includes an objective to address the elimination of premature discharges through PRO review of the appropriateness of the timing of patient discharge from the acute level of care.

- PROs will review each case under review to assure that appropriate discharge planning has been done.

Your third concern was about possible decreases under the PPS in the quality of care.

- There is no evidence that the new Medicare payment system has had a negative impact on the quality of health care for beneficiaries.

- PROs are responsible for monitoring the quality of care given to Medicare beneficiaries in the acute care/hospital setting. There are several ways in which PROs currently identify and respond to quality of care problems experienced by Medicare patients.

  - PROs are expected to identify quality of care issues and to investigate and correct any improprieties they identify.

  - PROs specifically look at unnecessary readmissions and transfers to determine whether patients are being prematurely discharged from hospitals.

  - PROs investigate individual complaints from beneficiaries about poor quality care.

  - PROs develop and analyze hospital, physician and patient data profiles to identify aberrancies which may be indicative of poor quality and thus require more intensive review and corrective action.

  - When quality of care problems are identified, PROs institute corrective actions.

- A major change in the new Scope of Work is the increased focus on quality of care issues, which specifically involves:

  - Focusing review on discharges to assure that beneficiaries are not discharged before they are well enough to leave the acute care setting.

Senator Kerry

- Focusing review on poor performing providers and practitioners.

And finally,

o We have no evidence that patients are not receiving necessary care because of hospitals denying access to care for them. In spite of declining admissions, Medicare still pays for over 28 percent of all hospital care provided in the Nation.

o And since the Prospective Payment System makes special provision to pay for patients who stay unusually long in the hospital or whose care costs unusually more than most patients with the same diagnosis, we do not believe that hospitals are limiting access to care for Medicare patients.

PHYSICIAN FEE SCHEDULES

Senator Kerry

Question: Do you continue to believe a fee schedule would be the best alternative to the current system? Do you believe a form of prospective payment could be applied to physician reimbursement under Medicare?

Answer: Although there are aspects of both fee schedules and DRG-based payment that might make either an improvement over the current system, both approaches have drawbacks. Capitation, making a single payment to a person or entity which would then be responsible for arranging for all physician services, is the only option that addresses both the price and the utilization of services while still providing quality care.

Fee schedules would provide limited additional control over the price component of program increases, while providing no additional incentives for control over utilization/intensity. Although a DRG-based payment system may seem somewhat technically feasible, there are many serious implementation issues that would need to be resolved.

There has been a rapid growth of enrollment in TEFRA HMO/CMPs, and the Department is proposing to expand the capitated options available to beneficiaries through the use of vouchers. The Department is also exploring, through demonstrations, a variety of new approaches to capitation. Clearly, not all beneficiaries will be served by capitated systems for some time. Therefore, there is a need to examine steps that could be taken in the near term to refine the current payment system and to maintain constraints on spending. However, I believe that, in the long run, approaches which foster competition and consumer choice, rather than more elaborate regulatory options, are the best ways to achieve the provision of quality care services while restraining the growth of spending for health care.

Senator Kerry

JOBS PROGRAMS

QUESTION

How would you expect to respond to proposals to offer greater flexibility for States in fashioning job programs for low-income recipients versus proposals to restrict State initiatives of this kind?

ANSWER

I share the Senator's view--and that of President Reagan--that we have an obligation to help welfare recipients become self-sufficient. I was pleased to learn that 38 States have implemented one or more of the work programs options which have been made available to them since 1981, and that these programs, though new, already are showing impressive results. This success is in large part due to the commitment and innovative approaches taken by States. The Administration has responded to this success by modifying earlier work program proposals to reflect the experience of the States.

The Administration's Work Opportunities Proposal, which has been introduced in both Houses of Congress, incorporates many of the activities which States have found to be successful in helping welfare recipients enter the workforce. Using the options afforded in our legislative proposal, States also would have flexibility to develop programs which meet their needs. Further, States would have the authority to propose new programs as demonstration projects.

I can assure you that as we develop next year's budget and legislative proposals, I will carefully review any work program proposals to ensure that we provide sufficient flexibility to allow States to meet the needs of their welfare recipients.

Senator Kerry

FRAUD, WASTE AND ABUSE

QUESTION

Over the past two years, the Massachusetts Public Welfare Department has made tremendous strides in reducing fraud, waste and abuse in its programs. In AFDC, Massachusetts has cut the errors from over 11% down to 4%. In light of this kind of improvement in the error rate by States would you expect to retain the HHS position that costly penalties must be applied to the States for remaining error rates?

ANSWER

The Department is required by law, the Michel Amendment and TEFRA, to limit Federal matching for excess erroneous AFDC payments unless a State can show that it made a "good faith" effort under extraordinary circumstances to meet its target. In 1979, dissatisfied with progress in lowering error rates and the pace of Federal regulations, Congress established, by statute, 4% as a maximum error limit up to which the Federal government would match. This limit was to be achieved by FY 83 in annual, one-third increments. In 1982, Congress further emphasized its determination to limit Federal funding for erroneous payments by establishing a 3% maximum error limit for Federal matching to take effect in FY 84.

The fiscal disallowances are not penalties or fines. They are simply a limit on the level of misspent money which the Federal government is willing to match. Limiting Federal matching for erroneous State expenditures has contributed substantially to the decrease in the national error rate from 16.5% in FY 73 to 6% in FY 84, and error rates continue to decrease. If the national error rate had continued at the 16.5% level, for FY 81, approximately $2.1 billion would have been paid erroneously.

We believe that the real issue is the extent to which the Federal government should be expected to continue to subsidize erroneous State expenditures. We commend States for their efforts in error reduction, but implicit in our responsibility to administer this important program is a commitment to make sure that the benefits we provide go to those for whom they were intended. Failure to meet this obligation, undermines the integrity of the program and public confidence in it.

Senator Kerry

AFDC - QUALITY CONTROL

QUESTION:

As you know, in AFDC alone the States are threatened with over one billion dollars in sanctions through 1989 and if those penalties are assessed, it is clear that States will not be able to afford the staff and computers necessary to improve managment.

ANSWER:

The amount of the disallowances is quite small in comparison to the total amount of States' erroneous expenditures. Disallowances of $69.1 million for FY 1981 represent only 7% of the erroneous expenditures of $973 million attributed to all States for that year. When projected through 1989, the estimated disallowance amount of $1.1 billion nationally constitutes less than 15% of the over $7.6 billion in estimated erroneous expenditures. If program improvements were made to reduce errors, additional funds would be available for the proper administration of the AFDC program. During FY 1981 through FY 1984 (the only years for which official error rates have been published under the Michel Amendment), Massachusetts expended over $161 million in erroneous AFDC payments. For those periods, the potential disallowances total approximately $26 million -about 1/6 of the erroneous expenditures.

In addition, a recently completed study by Touche Ross, Inc. addresses the issue of error reduction. The study establishes beyond doubt that States can control their error rates, and that effective error reduction can be accomplished at a reasonable cost. Based on a survey of 23 States, the study also shows that many States have not fully implemented the low-cost practices identified which appear to have the greatest impact on AFDC errors. The Touche Ross study was sent to all States to use in implementing low-cost error reduction.

Finally, enhanced Federal matching funds have been available since 1981 to assist States in the design and implementation of computer systems to assist in statewide AFDC administration and program management costs. These monies have been available at the 90% funding level, and many States (35 as of 12/85) have availed themselves of this assistance. Massachusetts was recently approved for this enhanced aid.

Senator Kerry

AFDC - QUALITY CONTROL

QUESTION:

Would you expect to continue Secretary Heckler's one year moratorium on penalties when States are implementing new Federal policy in the area of Medicaid and AFDC?

ANSWER:

I assume the reference is to the quality control modified procedures by which agency errors, associated with the implementation phase of new statutory requirements, are not counted in the computation of the error rate. All modified procedures have expired as of the present time. Depending on the nature of any new statutory requirements, I would expect that a modified procedure would accompany the implementation phase of the new provisions.

Senator Kerry

AFDC - FOOD STAMP COORDINATION

QUESTION:

What do you believe you can do to improve the consistency of federal public assistance programs? Would you be willing to met with USDA Secretary Block to review these issues?

ANSWER:

HHS and USDA have recently undertaken a major new initiative to improve the consistency between the AFDC and Food Stamps programs. The most important step in this initiative has been issuance of a joint Notice of Intent to Develop Regulations last February. Under this notice, the two Departments solicited comments and recommendations for changes which could be made in regulations to improve consistency between the two programs. Department staff also met with representatives of major interest groups, such as the American Public Welfare Association, to obtain further suggestions. A joint working group reviewed all the suggestions and is drafting a joint Notice of Proposed Rules. The target date for completion of this notice is February 1986.

The efforts to date have focused on eliminating regulatory differences. The staff also identified significant statutory differences which could not be addressed under regulatory authority. The next logical step would be to explore the statutory differences and to identify areas where changes could be made, given the differences in the target populations and purposes of the two programs. From this exercise, legislative proposals could be developed.

I would be willing to meet with USDA Secretary Block to review these issues, and I will continue to commit the staff resources necessary to continue progress in resolving them.

Senator Kerry

AIDS

Q: The tragedy of the AIDS epidemic has been recounted week after week in our Nation's press, with stories describing both the victim's plight and the fear in our communities as we come to grips with the disease. Not surprisingly, Secretary Heckler recently stated that AIDS is the United States' number one public health priority.

Do you agree with Secretary Heckler's statement and if so, what do you believe should be the Federal Government's role and responsibility in dealing with the AIDS epidemic--specifically in the areas of public education and prevention, research and development, and treatment? Despite the current budgetary situation, do you believe that the AIDS epidemic constitutes such a grave threat to our Nation's public health that funding for AIDS public education and prevention, research and development activities should be given a high national priority, determined by whatever level can be used productively in the effort to bring a halt to the disease as rapidly as possible?

A: AIDS is certainly a pressing public health problem. You can be assured that it will be a top priority with HHS as I assume the leadership. In 1986 we will be greatly expanding our efforts in drug development, prevention and education. Many of these efforts are spelled out in the PHS Plan for the Prevention and Control of AIDS. An outline of that plan (attached here) clearly sets out the areas we will continue to pursue in the coming year.

We feel that the levels of funding for AIDS are adequate to support all opportunities at hand that might bring a halt to the disease as rapidly as possible.

ARTICLES—POLICY

Public Health Service Plan for the Prevention and Control of Acquired Immune Deficiency Syndrome (AIDS)

Foreword

The PHS Executive Task Force on AIDS has developed this framework within which the Public Health Service is working to control and prevent acquired immune deficiency syndrome (AIDS) by the year 2,000. Our comprehensive plan is based on the state of the art since the isolation of the human T Lymphotropic Virus-III and development of the blood test to detect evidence of infection by the virus.

The plan includes broad-scale information and education activities in addition to research efforts to develop a vaccine, and treatments to fight the AIDS virus and restore functioning of the immune system.

Within each of these areas the PHS agencies have developed comprehensive plans of action. Programs to effect behavior changes for persons at risk and provision of up-to-date information on AIDS are important features of the plan, which assumes that a vaccine and effective therapy may not be immediately available. This outline and the specific plans of action are dynamic—as new information becomes available, steps will be modified accordingly.

The plan was developed as a continuation of the Public Health Service's extraordinary efforts to deal with this tragic disease almost since the first cases were reported in 1981.

James O. Mason, MD, DrPH
Acting Assistant Secretary for Health

PURPOSE

This document provides an outline for the key goals and objectives that must be met to achieve prevention and control of AIDS. The plan calls for action by Federal agencies, State and local health departments, professional organizations, and volunteer groups. Many of the specific objectives cannot be expressed in measurable terms because of inadequate current information, but they are included here even though modifications will be made as more data are generated.

I. PROBLEM

A. AIDS is a very serious, often fatal, disease caused by the virus HTLV-III.
B. The incidence of AIDS and infection with HTLV-III is increasing steadily in the United States.
C. More persons are known to be infected with HTLV-III than have become ill. The incubation period for AIDS in adults may range from 1 to 6 years or more and in infants from 6 months to 5 years or more.
D. Infected persons may be capable of transmitting infection for many years, even though they may remain asymptomatic.
E. The ability of HTLV-III to persist in the infected individual results in a population of persons who may be at risk for years for development of severe illness.
F. HTLV-III infection is transmitted by infected sexual partners through exchange of body fluids, through equipment used to administer intravenous drugs of abuse, through contaminated blood and blood products, and from infected mothers to infants. Members of all population groups thus exposed are at risk.
G. No effective vaccine or therapy exists.

II. ASSUMPTIONS

A. A person with a repeatedly reactive HTLV-III antibody test is infected with HTLV-III and able to transmit the virus to others.
B. Psychosocial and medical problems will increase as the number of AIDS cases grows and HTLV-III infection spreads.
C. The more HTLV-III infection is disseminated throughout the population before effective control measures begin, the harder it will be to bring it under control.
D. Because there is no means of intervention during the long incubation period to prevent severe AIDS, a vaccine that prevents infection will be an effective tool for control only after it has been in use for several years. On the other hand if early therapy becomes available to reduce infectiousness in those already infected, and if persons at risk take responsible preventive measures, control of AIDS will be realized much sooner.
E. It is unlikely that a vaccine or therapy to substantially limit transmission will be generally available before 1990.
F. Broad scale prevention and control activities, emphasizing educational and information exchange, must begin in the absence of available vaccine and specific therapy. They should be based on current best public health judgment.
G. Demonstration and evaluation projects are needed to determine the efficacy and cost-effectiveness of prevention and control strategies.

III. GOALS

A. By 1987, reduce increase in transmission of HTLV-III infection.

c. Encourage proper personal hygiene among infected persons.

C. Design and evaluate improved prevention and control measures.
   1. Develop and evaluate better approaches for detecting infection.
      a. Determine antigenic, genetic, and other variation among HTLV-III isolates.
      b. Develop and evaluate new antigen tests.
      c. Cooperatively develop guidelines for use of currently available and new tests.
   2. Develop and evaluate active immunoprophylaxis.
      a. Convene scientific advisory committees to plan for development and evaluation of vaccines.
      b. Characterize HTLV-III antigens biochemically and structurally to determine the specific component parts of the virus against which the antibodies generated by a vaccine would react.
      c. Develop specific candidate vaccines including subunit products, synthetic peptides, genetically synthesized antigens, and others.
      d. Develop new means of preparing, packaging, preserving, and transporting vaccine.
      e. Develop new, effective methods for delivering vaccine to substantial numbers of people.
   3. Develop and evaluate passive immunophylaxis, using artificially prolonged antibody.
   4. Develop and evaluate drug and biologic therapy including antivirals, immune stimulants, and combinations of these.
      a. Evaluate existing candidate compounds in laboratory systems and clinical trials.
      b. Design, produce, and evaluate new drugs based on results with existing compounds.
      c. Develop new immune stimulants and test available stimulants in animals or clinical research objects; investigate reconstitution of immune system, e.g., bone marrow transplantation.
      d. Test immune stimulants combined with antiviral therapy against HTLV-III.
      e. Evaluate host factors and possible cofactors.
   5. Develop and improve animal models to accomplish studies that cannot be done with humans or *in vitro* systems.
      a. Test candidate vaccines and drugs in chimpanzee and rhesus monkeys, which are the only animals shown thus far to be infected with HTLV-III.
      b. Use existing animal models and seek new species for study of animal retroviruses related to HTLV-III, e.g., feline leukemia in cats and retrovirus infection in nonhuman primates. Study agents that control these viruses.
   6. Assure that adequate facilities exist to support studies in the development and evaluation of vaccines, antivirals, and immune stimulants listed above.

D. Design and promote prevention and control programs that will enhance effectiveness by incorporating new intervention tools (vaccines/antivirals) as they become available.

AGENT ORANGE — Senator Kerry

QUESTION:

I understand that the Cabinet Council Agent Orange Working Group is being dramatically restructured -- with the membership being reduced from twelve agencies and departments down to only four and with no more monthly meetings being held. It is my sense that the working group has been a very significant force for providing leadership and direction to the Federal government's efforts regarding the effects of Agent Orange, and of Dioxin generally, and I am troubled by this change in its size and apparent importance. Since HHS will remain a part of the working group, although reduced to four, can you please explain the reasons for the changes and whether you believe the role of the working group can be carried on by some other entity?

ANSWER:

It is my understanding that the important work of the Agent Orange Working Group (AOWG) is not diminished but continues to be carried out by its most important element, the Science Panel, which meets monthly (and recently weekly) as needed. The Advisory Committee meets as needed. No members have been dropped from these two sub-groups. The overall Agent Orange Working Group which reports to Mr. Meese and the Domestic Policy Council has dropped some agencies that did not attend the meetings or who no longer had any role (Action, Council of Economic Advisors, Labor, etc.). The main players are now to be at the Deputy Administrator, Deputy Secretary, and the Under Secretary level and will make high level policy decisions based on the work of the two AOWG sub-panels.

I have been advised that streamlined AOWG does not need to meet monthly as it is now in a stage of monitoring scientific research and results. Not a diminished role but a more effective public policy making role at a higher level is now in effect.

Senator Kerry

NATIONAL INITIATIVE ON TECHNOLOGY AND THE DISABLED

QUESTION

Last week a hearing was held before this Committee on a new initiative underway at the Department of Health and Human Services. This program, the National Initiative on Technology and the Disabled, is intended to be a partnership between the government and the aerospace and other high-tech industries to design, develop, and foster new applications of technology for the more than 35 million Americans who confront disabilities.

What is your opinion of this program? How vigorously do you plan to continue the Department's role in this program? Do you feel this program is sufficiently progressing for meeting the needs of this Nation's handicapped, particularly the needs regarding housing, transportation, and employment? What plans do you have for monitoring the activities of this program?

ANSWER

I support the efforts of the National Intitiative on Technology and the Disabled to use the newest technologies to meet the needs of handicapped Americans. This initiative should not, however, supplant Federal programs to provide housing, transportation and employment services for the disabled. While I believe the program should continue, I will monitor it closely and will at the same time work to assure tha Federal government meets its responsibility to improve the quality of life of our handicapped citizens.

Q. Let me begin by asking, whether in your judgment, liver and heart transplants are therapeutic medical procedures?

A. To the extent that death might be avoided as the result of receiving a transplanted heart or liver for some patients, those procedures are clearly palliative. Whether these treatments of last resort can be considered as therapeutic in the sense that the recipient is returned to normal functioning with a good probability that there will not be a recurrence of the end organ disease remains to be established. Liver transplantation for children suffering from biliary atresia is clearly a sound therapeutic medical procedure and is a treatment of choice as well as a treatment of last resort. While there is evidence of increasingly good survival for recipients of transplanted hearts and in some cases, for the recipients of liver transplants, a design to stimulate the availability of these procedures through reimbursement is at the present time premature.

Sen. Gore

ORGAN TRANSPLANTS

Q: The NIH consensus development conferences on heart transplants and on liver transplants both stressed the importance of "institution and patient selection criteria" in finding these procedures to be accepted medical practice. Their findings state over and over again that we must limit these procedures to designated centers that meet rigorous scientific standards, and that can do enough procedures each year to maintain the necessary skills.

Despite the importance the medical experts have placed on limiting transplants to designated centers, so far the Department has refused to follow these recommendations, causing a dangerous proliferation of transplant programs. I fear this will have tragic results.

What is your opinion of limiting complex medical technologies such as organ transplants to a limited number of designated, specialized centers that meet established medical criteria? What role should the Department of HHS play?

A: The Department has proceeded consistent with the recommendations of the consensus development conferences with respect to institutional and patient selection criteria. What the Department has not done is to stimulate proliferation of transplant programs by prematurely determining that they should be paid for under Medicare. The materials developed by the consensus development conference, together with other criteria which have been developed by the Department are available to the transplant community. A proliferation of transplants still occur in a small proportion of the transplant facilities. It is the expectation of Federal financing for these procedures, together with the interest of medical science and developing new approaches that have led to the increase in the number of surgical teams willing to attempt transplantation.

I believe that the Department should continue to work with the transplantation community to define the medically appropriate cirteria for patient selection and institutional participation in transplantation programs, while we are developing a data base which will permit the determination of the clinical efficacy of these procedures. We much establish which procedures are appropriate for which kinds of patients in a way that will optimize the likelihood of a satisfactory outcome for individual patients. That process must minimize the risks of individuals who are appropriate candidates, particularly in institutions which do not have the requisite experience not just for the transplant but for the postoperative management of transplant recipients.

Sen. Gore

MEDICAL TECHNOLOGIES

Q: Much of the difficulty and debate in deciding whether programs such as Medicare should cover a medical procedure such as transplants has focused on the question of "experimental" vs. "accepted medical therapy"--a question whose answer is based on our capability to assess medical technologies.

How do you rate our current ability to evaluate new medical technologies, and what do you believe is the proper role for government in the technology assessment process?

A: While there is always room for improvement, our ability to evaluate new medical technologies is quite satisfactory. But, there are two problems. First is the ability to make judgments of the relative clinical effectiveness of the variety of diagnostic and therapeutical interventions which biomedical research has made available. These involve not only the difficulty of making relative clinical judgments, but also the questions of cost benefit and cost effectiveness. These, of course, include making determinations of social value which are not questions which can be satisfactorily addressed solely on the basis of clinical evidence. A second problem is that proper evaluation of medical technology is time consuming and the public is not willing to tolerate the delays which are almost always necessary in order to establish an adequate empirical base for the scientific analysis.

ORGAN TRANSPLANTATION Senatore Gore

Q: Last year, in response to the problems posed by rapid advances in organ transplantation and the resulting shortage of donor organs, Congress rejected (in the House by a vote of 379-25) proposals supported by the Administration for prolonged study of the problems, and instead overwhelmingly passed (House: 369-6/Senate: unanimously) a comprehensive package (P.L. 98-507) of programs designed to dramatically increase the number of donor organs.

Unfortunately, as yet, the Department has only set up a task force, also required by law, and has all but ignored the other provisions of the law. I can say without any doubt that Congress considered these other provisions of the law the most important and most in need of immediate implementation.

Dr. Bowen, can I get your commitment that if approved as the new Secretary of HHS you will take immediate steps to promptly and fully implement all provisions of P.L. 98-507?

A: Senator Gore, you are quite correct in your observation that up until very recently, the Department has focused its efforts toward completing the statutorily mandated assignments of the Task Force on Organ Transplantation.

It is important that as we implement the law, we rely on the expertise of the Task Force. Many issues are still being debated by the Task Force and differences of opinion still exist. The final report will give us direction from a consensus of the organ transplant community as a whole. With this information, we will be better able to implement the law and have the impact on organ procurement and transplantation that was intended.

HEART TRANSPLANTS Senator Gore

Q. In 1980, NIH and the Public Health Service recommended that Medicare deem heart transplants safe and effective and reasonable and necessary. The Department requested further study on how best to cover this complicated medical technology. That Department received the study, the National Heart Transplantation Study in October 1984, and released it in publicly in a press conference in May 1985.

At that time Secretary Heckler promised to finally make a coverage decision by the end of the summer. We are still waiting for that decision. Each day we wait more lives are lost, and greater confusion permeates the transplant field (proliferation of programs).

Dr. Bowen, can you give me your assurance that you will do your utmost to see to it that a decision providing coverage will be made within the first month you become Secretary?

A. I will review the history and recommendations of this issue as soon as possible but I am not prepared at this time to give you my assurance that the outcome will be to provide reimbursement under Medicare.

Senator Gore

ORGAN TRANSPLANTS

Q. In October, the Task Force on Organ Transplantation established by P.L. 98-507 sent Congress and the Secretary of HHS a report on immunosuppressive therapies as required by P.L. 98-507. The report recommends "the establishment of a joint Health Care Financing Administration-Public Health Service program to provide immunosuppressive medications to transplant centers for distribution to financially needy Medicare eligible transplant patients."

On November 14, 1985, the Senate passed a sense of the Senate resolution asking the Secretary of HHS to "immediately reconsider the Medicare liver transplant coverage decision" and to remove the current restriction on liver transplants for those over 18 years of age.

Can you tell me what plans the Department has for implementing these two items?

A. We are currently reviewing the first report of the Task Force on Organ Transplantation.

When the decision was made to provide Medicare reimbursement for liver transplants in children suffering from biliary atresia, a process was initiated to collect data with respect to the potential clinical indications and outcomes for adults. The NIH has established a liver transplantation registry and is presently documenting patient outcomes. Because of the large number of diagnostic indications for which liver transplantation is being under taken, resulting in a relatively small number of patients in each category, it will require several years of data collection to create an adequate data base on which a decision can be based. If evidence becomes clear with respect to particular diagnoses where the outcomes are known to be favorable and where there is a low probability that the disease which originally lead to liver failure would reoccur, we will consider coverage on a diagnosis by diagnosis basis.

American Lung Association

TUBERCULOSIS

QUESTION:

The highest incidence of tuberculosis occurs among poor inner city blacks and in areas that have a large influx of refugees such as Miami. Because tuberculosis is concentrated in these areas, doesn't it make sense to target federal expertise and resources on these areas?

ANSWER:

In 1984, 22,255 cases of tuberculosis were reported to CDC, for a rate of 9.4 cases per 100,000 population. The U.S. 1984 case rate for whites was 5.8 per 100,000 population compared to a case rate of 29.9 for nonwhites. The case rate for persons living in 57 cities with populations of 250,000 or more was 19.3 per 100,000 - more than twice the national rate. Urban rates ranged from 49.9 per 100,000 in Miami, Florida, to 2.3 per 100,000 in Omaha, Nebraska. Eight cities had rates at least three times the national rate: Miami, Florida; Newark, New Jersey; Atlanta, Georgia; San Francisco, California; Tampa, Florida; Oakland, California; Honolulu, Hawaii; and Washington, D.C.

CDC's tuberculosis technical consultation and assistance are targeted primarily to health departments and other providers in areas of high disease incidence. Specifically, in each of Fiscal Years 1983, 1984, and 1985, CDC awarded $5 million in Cooperative Agreements to 48 State and city health departments with areas of high disease incidence. Cooperative Agreement funds have been used by the recipient health departments primarily to employ outreach workers in the high incidence areas for field followup and directly observed therapy of persons with tuberculosis who otherwise would not take their medication.

Although CDC and the Federal government play an important role in the prevention and control of tuberculosis, we believe that States and localities should have the primary responsibility for establishing effective control programs.

American Lung Association

TUBERCULOSIS

Q: When the American Lung Association, then known as the National Association for the Prevention of Tuberculosis, was founded in 1904, tuberculosis was the number one health menace in the United States, but 20,000 cases continue to be reported each year around the country, and globally tuberculosis remains an immense public health problem. How can the United States take the lead in the eradication of this age-old highly contagious disease?

A: Tuberculosis does remain a problem in the United States and throughout the world. Infection with the tubercle bacillus may be the most prevalent infection in the world. In many developing countries, more than half the population is infected by the time they reach adulthood.

The Public Health Service works closely with the American Lung Association (ALA) particularly with ALA's medical affiliate, the American Thoracic Society. We are pleased that this voluntary agency continues to work toward the eradication of tuberculosis, a disease which, in theory, is both curable and preventable.

From a worldwide perspective, CDC has maintained, and will continue to maintain, a close working relationship with the World Health Organization (WHO), the International Union Against Tuberculosis, and other groups concerned with the control of tuberculosis in the world. We are very supportive of WHO's new tuberculosis research program on immunology and have indicated our interest in serving as the WHO Coordinating Center for a proposed program on new drug development.

The United States can take the lead in the elimination of this age-old disease. In our report to the Senate Committee on Appropriations, we outlined the three steps necessary to hasten the elimination of tuberculosis from the United States. These steps included 1) more effective application of existing methods for prevention and control; 2) initiation of basic and applied research efforts using modern biotechnology to develop more effective, simpler, and less expensive control methods; and 3) rapid and effective transfer of new prevention and control methods into field operations.

American Lung Association

PPS AND CHRONIC DISEASES

Question: Under the PPS the utilization of hospital resources and the length of stay of patients with such chronic diseases as emphysema and chronic bronchitis are extremely variable and unpredictable. Do you see a risk in these patients being labeled as undesirable by hospitals and in a broader sense, as we foster competition among health insurance plans, how does the Federal government assure continued access to quality health care for patients affected with chronic diseases?

Answer: The fact that individual cases within a DRG may vary in the amount of resources consumed should not serve to make patients who fall within it undesirable. The variability produces both "winners" and "losers" and, as hospitals gain operating experience under PPS, the fear of various types of patients which your question anticipates should be dissipated. In the event that a DRG is identified as not being clinically coherent or as not embracing an appropriate resource range, HCFA can reclassify the cases into other DRGs in order to avoid inappropriate results. Thus, I do not believe that variability itself is necessarily a problem but, if it proves to be, I am prepared to make the changes necessary to correct it.

I believe that increased competition will increase access to care for individuals with chronic illnesses. In particular, I would note that various types of capitation arrangements create situations in which there is a prepayment in return for the guarantee of treatment. Thus, there is less opportunity for an organization providing care under such an arrangement to avoid individuals who become chronically ill.

SMOKING EDUCATION American Lung Association

Q: Smoking is the number one preventable cause of death in the United States. The Surgeon General has called for a smoke free society by the year 2000.

What additional steps can be taken to bring about a smoke-free society?

A. The problem of smoking and its effect on health is a national one and one which cannot be solved by government alone. If our efforts are to be successful, it will require a total effort of all society, including those of government, health care, the community, and the individual. We must have programs of information, education, and where applicable, regulation. We must increase our efforts to inform all our citizens about the dangers of smoking; to persuade children not to start the habit and convince adults who smoke they must quit. History has shown however, that we have achieved considerable success in reaching our goal. Over 34 million smokers have successfully quit and fewer and fewer children are now adopting the behavior. These changes are beginning to have a sizeable benefit on the health of this nation and will continue to do so in the future.

American Lung Association

HEALTH STATUS OF MINORITIES

QUESTION:

A recent report released by the Department of Health and Human Services brought to the fore some very disquieting facts about the health of minorities in the United States. What do you propose we do to narrow the gap between health care for minorities and the general population?

ANSWER:

The Task Force on Black and Minority Health acknowledged that the factors responsible for the health disparity are complex and that diversity within and among minorities necessitates activities, programs and data collection tailored to meet their health needs.

Recommendations included incorporating minority health initiatives into existing HHS program areas in order to address health conditions amenable to immediate improvement; achieving greater public and private involvement in a common effort to address the disparity; resolve unanswered questions through a concerted program of research and data collection; and seek new strategies to ameliorate the inequities.

Within the Department there has been created a new office under the Assistant Secretary for Health to help implement these recommendations including developing new directions for Departmental activities that would help reduce the minority health disparity.

American Lung Association

CHILDHOOD RESPIRATORY DISEASE

Q: Childhood respiratory diseases are the leading causes of death in the first year of life and there is increasing evidence that early injuries to the lung can be magnified in later years and may predispose the adult to chronic lung disease. What should the Federal Government do to prevent childhood respiratory diseases and to minimize its sequelae?

A: The Federal Government has supported a number of research projects in this area. Many of these projects have been conducted in the Specialized Centers of Research sponsored by the National Heart, Lung, and Blood Institute as these problems require multidisciplinary approaches to understanding the natural history, pathogenesis, and possible methods of prevention.

One of the important advances made by the pulmonary research scientist has been development of methods of diagnosis of pulmonary abnormalities in early childhood with advances in pulmonary function technology applicable to the less cooperative younger child. The development of simpler and more convenient methods for evaluating alternations in the immune system as well as in diagnosing viral infections has been of considerable benefit for both short-term and long-term prospective studies of the relationship of immunologic-allergic and infectious factors in causing acute and chronic respiratory disorders.

In spite of the tremendous advances that have been made over the past 10 to 15 years with respect to understanding the pathophysiology of a number of disorders producing chronic airflow obstruction in infants and children, many unanswered questions remain and much research still needs to be conducted so that the morbidity and mortality from these conditions can be minimized. The National Heart, Lung, and Blood Institute has recently completed an indepth review of the research needs and opportunities in the area of Pediatric Respiratory Disorders. The report of this review, in which dozens of pediatric pulmonary physicians and basic scientists participated, will be available in the spring of 1986 and is expected to be widely distributed throughout the United States and abroad. This report should stimulate additional research projects and lead to even more progress in this important area.

The CHAIRMAN. Well, thank you so much.

I realize that HHS is a giant organization with thousands of programs under its umbrella. But I would appreciate your stating for the record what you consider to be your primary objectives as Secretary of Health and Human Services?

Dr. BOWEN. Well, Mr. Chairman, the first thing to do, I believe, will be to get a good team in place; to expedite the overdue reports and regulations; to stress the preventive efforts, and state that I do prefer home health to institutionalization; and then to balance the interests of beneficiaries, providers, and taxpayers. I realize that these are sort of broad statements, but I wrote out a whole long list of things I perceive to be problems. I might mention a few of these. I do want to emphasize that I perceive them as problems, and not necessarily in the order in which I think that they should be taken up.

The area of catastrophic acute care and catastrophic long-term care; the whole care of defensive medicine; medical liability and malpractice insurance; violence and health to include murder, suicide, accidents, and abuse; strengthen the family; teenage pregnancies; AIDS; Alzheimer's; alcoholism; Reye's Syndrome and Herpes; vaccine shortages and vaccine risk insurance; preventive medicine for all ages, to include health and life styles; fairness again to the beneficiary, provider, and taxpayer; some disparities that exist in reimbursement of medical care providers; uncompensated care; the problems in rural areas; rural hospitals; the differential of longevity in infant death rates by race—we need to determine why and what to do; the abuse of children, aging, and spouses; food additives, and on and on and on. This is not a complete list but——

The CHAIRMAN. That is a pretty good list.

Dr. BOWEN. But those things I perceive as problems.

The CHAIRMAN. You have put some real thought into this. That is a good list.

As you know, for the past several years, there has been a nationwide public awareness about Reye's syndrome, a rare but serious illness that afflicts children and teenagers. A voluntary effort by the aspirin industry with the help and encouragement of HHS has been quite successful in educating the public about this condition.

As one part of the effort, nearly all aspirin products shipped since last August contain a label warning regarding the use of aspirin in children for chickenpox or flu symptoms.

The FDA recently concluded that consumer awareness about Reye's syndrome would be heightened even further and consumers better informed if the warnings were made uniform both as to content and as to location on the label. That conclusion is supported by the aspirin industry and members of this committee. Today we are announcing that particular regulation, which is really in the nature of a voluntary regulation.

Earlier today, HHS and FDA announced that they were publishing a proposed rule to accomplish this goal. And I and other members of this committee and Members of Congress, including Mr. Waxman and others over in the House, have encouraged this procedure.

I personally view this rule as an extremely important one as do other members of this committee.

Now, in order for it to be on containers during the next flu season, the rule has to take effect by early summer. And in view of the importance of this question to the public and to the committee, and in view of the need to provide manufacturers sufficient lead-time with which to comply with the rule before the next flu season, can you give this committee your commitment to complete the Department's review of comments on this rule and finalize it as quickly as possible consistent with your legal obligations under the Administrative Procedures Act?

Dr. BOWEN. Mr. Chairman, it will be easy to assure you that we shall do it, because I sincerely believe in it. I do want to congratulate you, other members of the committee, and Congressman Waxman, and all the others who have worked on it. I think you have done a great service to the children of America, and I think that the majority of physicians would support this.

The CHAIRMAN. I want to compliment Senator Metzenbaum publicly along with Congressman Waxman because they have had very strong feelings about this for a long time. And they and their staffs have worked very hard to help and resolve this problem.

Now, in view of your answer, will you make every effort to expedite the analysis and comments and publication of the final rule within 30 to 60 days after comments?

Dr. BOWEN. I shall.

The CHAIRMAN. OK.

One of the major problems of our society is the feminization of poverty. We all are or ought to be concerned about that.

I have introduced several major pieces of legislation designed to help women achieve self-sufficiency, including education, training programs, State- and employer-sponsored child care programs.

Will you work with me, Dr. Bowen, to provide the support to the Department of Health and Human Services to constantly address these particular problems?

Dr. BOWEN. Yes; those are also a priority.

The CHAIRMAN. OK.

This committee has jurisdiction over the Food and Drug Administration, as you know. It is my great hope that you and Dr. Young, for whom I have such great respect, will enjoy a very close and a very productive relationship. One of the areas of most concern to us, and I know the Commissioner shares this concern, are the delays and the obstacles in the approval process for drugs.

Because of such delays and obstacles I see the creativity process fleeing our country and moving to other countries. And I do not think we need to have such long delays.

While FDA has demonstrated that it can occasionally review promising new drugs rapidly, I think that still remains the exception at FDA. The need remains for new incentives to encourage staff to act more promptly, for more complete computerization and coordination, for tighter administrative control and followup on timetables, and for more resources, not only for approvals but also for enforcement under the law.

Will we have your help in the continuing process of modernizing and improving the FDA in its procedures?

Dr. BOWEN. Yes; I think it would be a great service to everyone if we could speed up the process. And it will be a pleasure to be on

the side where I might have some influence rather than to be a critic myself. I am on record in the past as having been critical of the same thing.

The CHAIRMAN. I have a lot of other questions but I am just going to submit them for the record and you can answer them in your leisure.

Let me turn to Senator Simon, and then I will turn to your own Senator, Senator Quayle.

Senator SIMON. Thank you, Mr. Chairman.

And we welcome you here, Dr. Bowen.

Dr. BOWEN. Thank you, Senator.

Senator SIMON. And let me just add that what I hear from my colleague here, from many mutual friends, I ran into Congressman Andy Jacobs and Bud Hillis yesterday, and both of them were singing your praises.

Let me—this is one chance just to get some kind of general impressions from you. From now on when you are before the committee, you are going to be on some specific item.

The prospective payment, DRG, sound in concept, but we are now running into problems where I have a letter on my desk right now from someone who—you know, the hospital wanted to save money, put him out before that person should have been put out, and that person died. Now, maybe that person would have died anyway, I do not know.

Do you think that whole DRG process should be reviewed, or what is your reaction to it?

Dr. BOWEN. Senator Simon, the purpose of the DRG's has been, I think essentially accomplished, in that it has reduced costs. It has also reduced the admissions, and has reduced the length of stay. But since that has been accomplished, the problem of early discharges may need attention.

There are reasons, of course, why it may seem like there are early discharges, when they are not. I mean the nature of some diseases is such that you could have a serious setback for no cause related to the physician or the hospital. Sometimes the patients may discharge themselves or sign themselves out. Sometimes there is dismissed judgment without any reason, and sometimes there could be overaggressive discharges. This does need to be evaluated so as to make sure that the quality of care remains high.

Senator SIMON. The AMA is suggesting a ban on smoking ads. Any reaction?

Dr. BOWEN. Yes; I saw that in the paper this morning. If you will permit me, I spent an hour or two trying to devise an answer because I was certain that somebody would ask it. This is my response.

Senator SIMON. I am a pretty good straight man for you here. [Laughter.]

The CHAIRMAN. You are not bad, Senator. There is room for improvement, but we think you are doing a pretty good job. [Laughter.]

Dr. BOWEN. As a physician, I believe the use of tobacco for most individuals does create a health hazard. I firmly believe that the potential hazards of tobacco use should be clearly placed on the labels so that individuals can make their choice. However, I do not

believe the opinion of most of the half million physicians of this country whose responsibility it is to care for the health of our people can be ignored.

The whole subject of the efforts of advertising on tobacco use needs to be studied and weighed while still offering some freedom of choice. Now, I realize that might be equivocating a little, but I am not——

Senator SIMON. Slightly, yes.

Dr. BOWEN [continuing]. Precisely saying "yes" or "no."

I do feel that the use of tobacco is a health hazard, but I also believe that if the individual is educated and told about these hazards, that maybe he should have the right to say I accept the hazards and do it.

Senator SIMON. All right.

If you do not get approved for HHS, with that diplomatic answer we may move you over to the State Department. [Laughter.]

What about the problem—I know I read sometime ago, when you were still Governor of Indiana, you talked at one point about the problems of the catastrophic illness.

Do you have any feeling as to what—and I recognize we cannot do it this fiscal year, perhaps next fiscal year—but down the road, what should we be doing in this area?

Dr. BOWEN. Well, I think there are two major problems in the catastrophic area. One is acute care, for somebody who is acutely ill, so to speak, for weeks and weeks, and has to remain in the hospital. It is tremendously expensive. The other is long term where they might have Alzheimer's and be in a nursing home for a long period of time. Both of those are really catastrophic situations for an individual.

On the Council, which I chaired in 1982 and 1983, and part of 1984, I believe, we did come up with some suggestions as to how the acute catastrophic care could be handled, and that would be simply with an addition to the part B premium which would permit unlimited number of hospital days. The premium that we had costed out showed that it could be done with the figures at that time at about $12 a month addition. For about $144 a year addition, you could get an unlimited number of hospital days. The reason for that being so inexpensive would be that the cost was spread over the whole 30 million or so people on Medicare.

But the good part about it, is that actually we think the individual might even be saving money because it would reduce the need for Medigap insurance that almost everyone carries to take care of that catastrophic end. Medigap insurance was usually a little higher than the $12 a month.

For long-term care for people with the chronic illnesses, we had suggested in a paper recently written that perhaps an IMA, an individual medical account, patterned after an IRA could be started—perhaps at the age of 35 or 40 or so—and continued during the higher earning years of one's life so that it could be devoted then to long-term care in the event it would be needed. That has not been costed out. It is just an idea.

Senator SIMON. Right.

Then just one final observation, Mr. Chairman.

In the area of NIH, I would simply urge you to take a good look at what we are spending and where we are doing it. Just as an example, mental health research is nowhere near as heavy in expenditure as, I think, it ought to be when you look at the costs of mental health in our society.

Back a few years ago, I just accidentally found out that they were going to be cutting back on cystic fibrosis research. Simply because they had to juggle some tough budget figures. And who headed the cystic fibrosis research then was retiring.

I think a good hard look at the whole NIH picture could be a real contribution to the Nation, say where should we really be spending these research dollars, and are there areas that are not receiving the kind of attention that they should be receiving?

But let me just add in a general way we are very pleased to have you as the Presidential nominee, and I look forward to working with you as the Secretary.

Thank you, Mr. Chairman.

Dr. BOWEN. Thank you, Senator.

The CHAIRMAN. Thank you, Senator.

We will turn to Senator Quayle.

Senator QUAYLE. Thank you, Mr. Chairman.

I do not have any questions for Governor Bowen. I just make an observation that many of our colleagues, Governor, would be here except we are in a number of conferences that are going on, and that is one of the reasons that some of them are not here.

And, second, I think it just shows that there is really very strong support for you personally and for your record in the past.

So, Mr. Chairman, I just again welcome the Governor to the committee. I congratulate again the President for making an outstanding recommendation. And I look forward to working with you, Mr. Chairman, Senator Kennedy, and others on this committee with Doc Bowen. And we will all be in for a real good cordial relationship with the new Secretary of HHS. He was a master as a Governor and Speaker of the House of Representatives, or Speaker of the House in Indiana. And I just look forward with a great deal of excitement and challenge to his becoming the next Secretary of HHS. And I do not have any questions.

The CHAIRMAN. Thank you, Senator Quayle. We will now turn to Senator Kennedy who has done a great deal in the area of public health.

Senator KENNEDY. Thank you very much, Mr. Chairman. I want to welcome Dr. Bowen to this committee, and congratulate him on the appointment, the recommendation by the President for this important position.

There is no more important position in the Cabinet than the Secretary of Health and Human Services, and no agency of Government touches the lives of more Americans; no agency of Government embodies the same degree of our national aspirations for a just and compassionate society.

No other agency of Government is so crucial to the health and the welfare of the young, and the poor, and the aged, and the American people as a whole.

There are 26 million senior citizens who depend on Social Security to enjoy a dignified and secure retirement. There are 30 million

elderly and disabled Americans who depend on Medicare for access to essential health care and freedom from devastating medical costs.

There are 11 million poor children. Their parents depend on Aid To Families With Dependent Children for access to food, clothing, and shelter.

There are 22 million poor Americans who depend on Medicaid to finance the health care they need. All Americans benefit from the biomedical research conducted in the National Institutes of Health, the public health activities conducted at the public health services, and all of us depend on the protections afforded by the Food and Drug Administration.

And just as there may be no agency of Government more important than the Department of Health and Human Services, there is no agency that has suffered a more savage and unrelenting assault at the hands of the current administration, and despite the pious talk of the importance of our national safety net, the administration has proven itself fundamentally hostile to Health and Human Services.

The administration has tried three times to cut Social Security and rob our senior citizens of the retirement income they deserve.

The administration has signed cuts in Medicare benefits and increases in Medicare premiums that will add $11 billion over the next 5 years to the already heavy health care cost burden our senior citizens must carry.

And the most recent administration budget proposed to add $15 billion in Medicare benefit cuts. We saw the actions in the continuing resolution yesterday.

We increase the deductible for the first day in the hospital by $92. Up 176 percent, the first hospital day cost for senior citizens, 8 million of them across this country. Because under the DRG's, as you understand, a shorter time in the hospital, more empty rooms, higher cost per day; that is the formula that is being used. We have been able to save on Medicare in terms of the expenditures of Medicare for the reimbursement of DRG's, and with the savings, do you think we have been able to get any recommendation from the administration to pass any of those savings on to the elderlv? No.

So, as of January 1, even with the Heinz-Kennedy amendment, that cost will go up $92. We hear a lot about no new taxes; you try to convince a senior citizen that that is not a new tax. Eight million of them are going to be paying that next year.

And just as the administration has tried to betray the promise in Medicare and Social Security, and not spared the poorest of the poor from unfair budget cuts, the Medicare provides essential health-care services to 11 million poor children, 5 million poor parents, 3 million poor senior citizens, 3 million poor, blind, and disabled senior citizens.

But despite the dreadfully low income levels that people must endure to qualify for Medicare, and the crisis and access to health care now faced by the poor, the administration proposed in its next recent budget, to cut Medicaid a staggering $15 billion over the next 5 years. Over 500,000 poor children have been dropped from Medicaid coverage in these last budget cuts. So you would think that everyone would favor the basic biomedical research that has

brought us the miracles of modern medicine, when the Congress appropriated enough money to fund the 6,500 new and competing grants last year. The administration tried to manipulate the grant, cut those grants 23 percent. The greatest opportunities in the history of NIH, made progress in the most basic and fundamental diseases, going all the way, cancer, heart, the rest. You know it, Doctor, as well as I do.

More approved grants probably than any time we have had in the history. Increasing problems in keeping young people involved, and older people involved in terms of the research and the recommendation.

So, Dr. Bowen does not have an easy job ahead of him if he is confirmed by the Senate. We never expected to have a philosopher-king named to the post, but we do have a political physician and a doctor of laws, and I welcome you to the committee and look forward to your expressing your views on many of the issues that concern us.

Senator QUAYLE. Mr. Chairman, I would like to withdraw that cordial relationship, in the statement that I had previously made. [Laughter.]

Senator KENNEDY. Oh, no. We will get along just fine.

The CHAIRMAN. I'll tell you: Senator Kennedy never misses an opportunity.

Senator KENNEDY. We will get along just fine, and Dr. Bowen knows that as well.

The CHAIRMAN. Don't be afraid, Dr. Bowen.

Senator KENNEDY. He is not afraid at all. [Laughter.]

Now the administration has proposed the deep cuts in the Social Security, and excluding the bipartisan Social Security compromise, the administration proposed or supported cuts that would take away $127 billion from Social Security over a 5-year period.

I believe that the Social Security benefits are a sacred promise between the Government and our Nation's senior citizens, and I would be interested whether you agree. Just for the last question. Or if you want to make any other comments, go ahead.

Dr. BOWEN. Well, thank you, Senator Kennedy, and I might mention for Senator Quayle, and Senator Hatch, that I have been in meetings with Senator Kennedy before when I was Governor. He appeared before the Governors' conference many times, so we have met several times.

Senator KENNEDY. That's right. That's true.

Dr. BOWEN. And I do not think there is any adversarial relationship.

Senator KENNEDY. None at all.

Senator QUAYLE. You have heard that speech before? [Laughter.]

Senator KENNEDY. He heard one similar to it, and you ought to check the record, Dan. He was not reluctant to express his views.

The CHAIRMAN. I do not want you to think that Senator Kennedy occasionally gets political, but——

Dr. BOWEN. Well, Senator, all I can say now is that I do not think there is anyone with more compassion for the poor than what I, as a physican, have been. I will make every effort to balance the needs of all the beneficiaries with the needs of the providers and with the needs of the taxpayers.

I will be as compassionate as I can, with the funds that are made available to do it with.

Senator KENNEDY. Well, that does not quite answer the question. I mean, what you could gather from that answer is that you are going to mix, you have an idea that you mix the benefits of Social Security into the providers, for example, in hospitals, or doctors, or the taxpayers, but Social Security is an independent funding obviously, as you well know, having been on the Cost Commission.

And I am just interested about what your own view—I will get into more specifics in just a few minutes. But I would want to know about your own view about the nature of the compact that we, as a society have, as the Congress, and as the President, has with our senior citizens. Whether you recognize that as a compact which will not be violated, or, whether you feel that, as the head of HHS, that you are going to be willing to see adjustment in terms of benefits in the future, and variations in terms of age limitations, or what. I want to hear some expression about how important you think that, whether you think there is a compact, and how important you think it is.

Dr. BOWEN. Well, I think that it is extremely important but I think we also have to consider the fact that over the next generation and a half, or so, that there is going to be an increase of 80 percent, in the people between the ages of 65 and 74.

There is going to be an increase of 220 percent of those between 75 and 84; a whopping 280 percent increase of those——

Senator KENNEDY. Are you talking Social Security or Medicare now?

Dr. BOWEN. I am talking about Social Security as it relates to the number of the people who are going to be on it.

Senator KENNEDY. Well, you are not trying to suggest to the committee now that it is your understanding that the Social Security Trust Fund is in serious financial trouble, now?

Dr. BOWEN. No, no, I have not said that at all. I am simply relating some figures to you that I think are relevant to the question.

Senator KENNEDY. But you are satisfied, as far as the integrity of the Social Security Trust Fund into, past the year 2000, aren't you?

Dr. BOWEN. Since the 1983 amendments, yes. I am satisfied.

Senator KENNEDY. What I am asking you is, given that understanding, can you see justifications for the reductions of benefits for the people?

Dr. BOWEN. You are talking about——

Senator KENNEDY. If it is your understanding that it is in a sound financial basis. Can you give the assurances—there are 32 million senior citizens that are listening for your answer about whether, given the fact that we have a Social Security Trust Fund that is financially responsible, that they can know from your statements here, that they have nothing to fear in terms of reduction of benefits? Can you say that?

Dr. BOWEN. I am trying to relate the figures, as I see them, that there will be a 280-percent increase of those above the age of 85 between the years 1980–2030, and that each of those will require about 1½ times the medical needs and medical costs of those at the age of 65. So, over that period of time, certainly, I think we have to look to the future instead of just to the 5 or 10 years ahead.

I also think we need to make note of the fact that when Social Security was in its early years, there were about 15 or 16.5 people working for every one that was drawing.

Right now, it is about 3.4 working for every 1 that is drawing. If you project that on ahead for another generation or two, it is going to be down to 1.9 working for every 1 drawing, and that is why I say you have to make some—you cannot make any absolute promises that there are not going to be some changes necessary to keep the program afloat over a long period of time.

Senator KENNEDY. You realize what the surpluses are going to be, Dr. Bowen. In the next 10 years, we are going to have surpluses, $600 to $700 billion.

Dr. BOWEN. Yes.

Senator KENNEDY. Well, that is worthwhile mentioning, too, in terms of a presentation, to talk about the viability. I would have thought that when I voted for that compromise, and we were given the assurances, we are a bipartisan group, that we were putting it on a financially sound basis on Social Security, given all the demography that you have mentioned here, and we know those figures.

I mean, all of us who certainly voted for that, and hopefully would have some understanding of them. And that you would be able to say on the basis of that particular compromise, that the Social Security trust fund is sound, is viable, and that you can give the assurances to the Social Security recipients in this country, that their benefits are inviolate, and given, over the time for the period that we included, we basically looked at that for a period of years.

Dr. BOWEN. Senator, there is no question that the Social Security fund is sound for the next several——

Senator KENNEDY. That is what I am addressing now. I will come to Medicare in a minute.

Dr. BOWEN [continuing]. Are sound for the next several years. There is no question about that.

The CHAIRMAN. But there is no guarantee you are going to have a $600 or $700 billion surplus, is there? I mean, I do not know who can make that kind of a claim, even though we have had a lot of claims made in the 1983 bill.

Dr. BOWEN. I do not know the figures——

The CHAIRMAN. I want to make sure that we do not bandy figures around just to——

Senator KENNEDY. Well, if you read the trustee's report, in the flowline, that is the basis for the figures that I am using.

The CHAIRMAN. I understand, but nobody can guarantee that.

Senator KENNEDY. No one is guaranteeing, but in any kind of presentation about what the facts are in terms of demography, and about the stress that is going to be placed on the system, I think it is also—and as a former member of the commission—I think also, when this particular issue is the lifeline, Social Security the lifeline of millions of elderly people, that they are going to be able to get some assurances about the Secretary of HHS, about the strength that he believes of the nature of this compact between the American people, and their Government, and a commitment from him that it will not be tampered with.

I think I have the floor.

The CHAIRMAN. You do. But would you yield for just one comment.

Senator KENNEDY. When I finish the thought I will be glad to.

The CHAIRMAN. Sure. As soon as you finish your thought.

Senator KENNEDY. I think that it is valuable that they have that kind of assurance because we have seen the yo-yo around here, playing with the administration recommendations in terms of cuts, and then alteration and change in their position.

And the commission established, I thought—to be very frank about it, I thought this was sort of a yes-or-no answer. I have other questions.

I am rather surprised that we cannot get a direct, straight answer with regards to the commitment on Social Security, that it is a basic compact, that you are strongly committed to it, that your understanding is that it is financially sound, and, that you could not understand how there would be circumstances where there would be any reduction in terms of the benefits. It would seem to me that that would not be that difficult to make, or am I missing something?

Dr. BOWEN. I guess with your long explanation I lost the question.

Senator KENNEDY. Well, can you make that statement?

Dr. BOWEN. I can say that——

Senator KENNEDY. Can you make that statement?

Dr. BOWEN. I can say that Social Security is here to stay, there is no question about that, and that it is sound for the next several years, but I cannot predict 25 years from now.

Senator KENNEDY. I am not talking—during your administration. You are not going to—I mean we wish you well——

[Laughter.]

Senator KENNEDY. But just while you are in there, Doctor. That is all we ask. Just while you are in there. Can you give us those assurances?

Dr. BOWEN. I do not know. I do not have any assurance of how long I may be in there.

The CHAIRMAN. Would you yield?

Senator KENNEDY. Can he answer that? Well, while you are in there, and then I will yield to Senator Hatch.

Senator QUAYLE. Just a little demographics.

Senator KENNEDY. Can you just give us those assurances, while you are in there?

Dr. BOWEN. I think that is relatively easy to give. It is here to stay.

Senator KENNEDY. OK. I will take that.

The CHAIRMAN. Now will you yield? The way I have interpreted Senator Kennedy, and, although I am not always good at interpreting Senator Kennedy, but I may be among the best at doing it, all he is saying is that the Social Security funds are not going to be tampered with.

You cannot guarantee how much money is going to be there or not going to be there. There is a system; there is a formula; there is a taxation process, and whatever comes comes.

But I think that is all he wants to know, is that nobody is going to tamper with those funds.

Dr. BOWEN. Well, that is easy to say. I did not understand the question, I guess.

The CHAIRMAN. Well, see, don't I ask much clearer questions than Senator Kennedy. [Laughter.]

Senator KENNEDY. Now maybe we can have an opportunity for me to ask my questions and then for you to ask yours: Mr. Chairman.

The CHAIRMAN. We are very happy to have you ask yours, Senator.

Senator KENNEDY. I will try and do that. I am glad to yield for a point, or an opportunity, but if we are going to have a chance to run through these, I would like to do it.

The CHAIRMAN. Go right ahead.

Senator KENNEDY. And then, obviously, everyone else gets a chance as well.

One of the recommendations that is being considered is the very significant reduction of personnel in the Social Security offices around the country.

I do not know how my colleagues, how their offices are, but a very significant part of the, both challenge and service, as elected representatives, is trying to help people with their Social Security checks.

It probably should not be so. The agency ought to be able to function and work in a timely manner, but as you well know, the amount of time that it takes in consideration and review of a case has been extended and extended, and extended, since I have been in the U.S. Senate.

And now, we have a proposal, given your figures of increasing numbers of people on Social Security, where they are going to reduce the personnel by almost 20,000, by 1991.

And I would hope that you would give us at least some opportunity—I do not know whether you have a reaction to that, just based upon your own knowledge of the service of the Social Security offices. But I wish you would let us know about what your estimate is going to be in the additional time it is going to take, in terms of processing.

Either the various checks that go out initially, or, dealing with those individuals, elderly people, that are living on a thread, many of them, and have no other supplemental income when their Social Security checks, for one reason or another, get sidetracked, or are mislaid.

Dr. BOWEN. Well, it is my understanding that there is a mandate that personnel in Social Security be reduced by 17,000 by the year of 1990, I thought. Maybe it is 1991.

Senator KENNEDY. 1991.

Dr. BOWEN. OK. I am advised that that is a very possible thing to meet, if we can continue with the modernization of the office procedures and office processes. Even with the reduction, that there can be increased services rather than any reduction in the quality of service, and certainly, that would be my aim, to make as efficient a Social Security Administration as we possibly could do.

Senator KENNEDY. Well, I will write you later about what the—and I would be interested in hearing from you, what the implications are going to be in terms of the services. I mean, we are very good here in loading up various agencies. We had the FDA. We gave them medical device legislation which I sponsored. We did not give them any more money to do it.

I opposed the Food and Cosmetic Act because the FDA was not getting the resources to be able to do it. So we are very good in adding additional burdens to INS and then complaining about it when they do not provide the services on it, Congress is.

And I think what we ought to do in the areas of Social Security, know what the implication in terms of services are going to be for the senior citizens. I will write to you in the future and give you a chance to look at it, but it makes a lot of difference to the people, I know in my State, and I think people all over this country about it, because increasing numbers of people are moving, and the length and time that it takes, and when that check is missed, the implications it has on families is very profound.

In the Medicare area, I made the point about the increasing shift that we have seen in recent times to the individual, both in the premium and the deductibility, recently, now, that we have, with very, I think, profound adverse health implications.

Effectively, for all of our senior citizens, they have about a $1,600 a year out-of-pocket expenses. We just added another $100 to it yesterday.

And most of the health insurance programs, the private health insurance, what?, are $200 or $300 deductibles. So they are already cost conscious. The rationale for deductible is to make people cost conscious on this and not overutilizations of services.

But I mean, the elderly have been so cost conscious for so long, that the argument loses itself. Now we have a suggestion that was made, and which I think you supported as the Chairman of the Advisory Council on Social Security, about deferring the age of eligibility from the 65 to 67.

I am just interested, if you would comment on—if that was your position, if that still is your position, and what you think will happen to people between the ages of 65 and 67 if that ever goes through, or if it is ever recommended?

Dr. BOWEN. Let me first tell you the charge that we received when we were appointed to the council. We were charged with finding ways to rescue a financially ailing program, and it was the estimate of the best actuaries going, that there would be between a $200 and $400 billion deficit by 1995.

We were asked to find ways to rescue the program, so to speak, and we came up with a series of possible answers, one of which was to increase the age of eligibility from 65 to 67.

As I recall, that would have reduced the deficit by some $75 billion right there. We then came up with other suggestions as to how to do it. We did not realize then, what has happened now, that the program would gain new life for another many years due to the prospective payment system.

So the recommendation to go from 65 to 67, was one of the means whereby you could help rescue the program.

Senator KENNEDY. Well, now, through the prospective payment system we are finding savings. Of course there are other questions in terms of quality which I hope, when you are confirmed, we will be able to get back to, and I hopefully would have your attention because that is——

Dr. BOWEN. Quality of care, sir, is my aim.

Senator KENNEDY. Good. But I understand now, therefore, that you would not suggest any such, or you would not favor a recommendation of moving Medicare from the 65 to 67?

Dr. BOWEN. That would be my present intention.

Senator KENNEDY. Well, the advisory committees of this last summer, their evaluation of the integrity of the Medicare system, shows that it is basically sound through the year 2000. A year ago, of course, they had a different recommendation, as I am sure you remember, about a trillion dollars in deficit.

And the biggest and the most significant way that that has been done is through prospective budgeting, but it has also had some other quality issues, which I hope we can talk about at some other time, rather than today.

But given the report, the current report of the advisory committee on Medicare, could you say that—could you find any possible justification for why the age limit ought to go from 65 to 67?

Dr. BOWEN. I see no emergency for it, but I will not say that in the future that it may not be raised. After all, the age of longevity has also gone up since the time the program was first started.

Senator KENNEDY. Well, when you make that recommendation, are you going to come up and tell us how you are going to look out after the people between 65 and 67?

Dr. BOWEN. I did not say I was going to make the recommendation.

Senator KENNEDY. Yes. Well, if you ever do, if you cannot—I hope that that will be at least something that you will be prepared to deal with it.

Dr. BOWEN. Sometime it will have to be looked at as the age of longevity continues to increase, which it will.

Senator KENNEDY. In 1980, as I understand, you addressed a leadership conference of the AMA, and UPI reports that in a speech you said that Federal authorities have portrayed physicians as greedy obstructionists trying to reap wealth from sickness.

And Federal authorities are trying to take over the practice of medicine.

Did you make that statement, or one like it?

Dr. BOWEN. I think I recall making such a statement.

Senator KENNEDY. Well, do you want to elaborate, or do you want to explain it, or——

Dr. BOWEN. Well, it is probably the way I felt, that the Federal Government should not interfere in the practice of medicine.

Senator KENNEDY. Don't feel that way around our chairman here today.

Dr. BOWEN. I still feel that there should be as much freedom as possible in the practice of medicine. There have to be some rules and regulations to prevent its abuse. But I believe that the situation has eased up some since I made the speech.

Senator KENNEDY. Well, maybe you can tell us about what particular Federal regulations you feel today are attempting to, or, are trying to take over the practice of medicine?

Dr. BOWEN. There was a time, I think, back in the 1970's, where total—and I put in quotes "socialization of the practice of medicine", was, I think, a threat, but I think that has subsided.

Senator KENNEDY. Well, I am not going to be satisfied—but what, specifically—that is a very general statement. I want to hear what, specifically—do you object to Federal regulation of medical devices?

Dr. BOWEN. No.

Senator KENNEDY. Do you object to Federal regulation, of the FDA, in terms of safe and efficacious drugs?

Dr. BOWEN. No. I do not.

Senator KENNEDY. All right. Well, what Federal—what are you driving at? What were the Federal regulators, for you to make that kind of statement? I want to know.

Dr. BOWEN. I did not make any specific statement at that time. It was just as general as what the question is here.

Senator KENNEDY. In the——

Senator NICKLES. Mr. Chairman, I wonder if we might kind of rotate some questions——

The CHAIRMAN. How long are you going to go on?

Senator KENNEDY. Oh, I have got, I have got——

Senator NICKLES. My questions will not take very long.

The CHAIRMAN. Well, I do not want to go to a 10 minute rule. I was hoping, Senator Kennedy——

Senator KENNEDY. Well, this is very important. I care very deeply about it and I am prepared to stay here as long as Dr. Bowen or—will agree, or wants to go.

Senator QUAYLE. That is what I was afraid of.

The CHAIRMAN. Well, why don't we do this: We can use the 10-minute rule and go back and forth, and I think if——

Senator KENNEDY. I will be glad to wait till everyone finishes and then I will be glad to go with my questions.

The CHAIRMAN. I think that is fair.

Senator KENNEDY. I would like to develop the whole theory and that is actually the way it used to, we used to do, but I am glad to follow the will of the Chair on it, and I will withhold until others have finished, and then I will indicate that I will finish my questions with the time it takes, necessary to do so.

The CHAIRMAN. Why don't we invoke a 10-minute rule in fairness to every Member of the committee, and we can go back and forth between the minority and the majority.

We will turn to Senator Nickles at this time. Because I have a lot of questions, too.

Senator NICKLES. Thank you, Mr. Chairman. I do not expect that my questions would take but 10 minutes, and Senator Kennedy was just getting warmed up, and I thank you, Senator Kennedy. I appreciate your consideration.

Dr. Bowen, welcome to this committee, and I would echo the comments made by your Senator, Senator Quayle. He speaks very highly of you and I can see why.

You have got an enormous challenge, and again, I congratulate the President for his selection, and for your willingness to serve in a very challenging capacity.

A couple of just comments and questions both. One, I notice where Dr. Rhoads was recently reinstated as Indian Health Services Director.

I commend that action by the President and I am assuming with your knowledge, anyway, and I would urge you to work with Dr. Rhoads and also with Mr. Swimmer, Assistant Secretary of Indian Affairs over at Interior, to make some improvements in the delivery of health care services to Indians of this country.

And I am not necessarily talking about just pouring more money. I can tell you that in Oklahoma, where we have the largest Indian population in the Nation, we have had many tribal leaders comment to us that a great percentage of the funds from Indian health services were going through the bureaucracy and not going into implementation of services, actually helping those people that we are trying to help. In other words, in bureaucracy and staff, and you name it. And I just make those observations to you.

I can also tell you that I have visited some of the facilities, and am bothered to some extent by the quality of health care.

I would like to see it improved. I would like to see some of the focus, maybe away from bureaucracy, into really trying to implement the health care, the dollars that we are actually spending.

And these comments are coming not just from me as a Senator, but also, relaying those comments from some of the chiefs, and some of the other tribal leaders in our State.

And I think Dr. Rhoads would do a good job, but I wanted you to be aware of the fact that I think there are some significant areas for improvement that need to be handled.

A couple of questions kind of quickly. DRG's and the process that we are going in Oklahoma, and now I am assuming Indiana and some other States—there are some real inequities on DRG's between various hospitals.

I personally took a survey of a lot of the hospitals in our State, and we found that some hospitals in some areas might be 30 miles apart but they may have double, or twice the difference, I guess, in reimbursements for DRG's, whether we are talking about pneumonia, whether we are talking about appendix, or whatever. I found the discrepancies and the variances to really be way out of whack and needing some adjustments, and I think there is some work being done on that in reconciliation.

But have you found that to be a problem and have you observed that as a problem?

Dr. BOWEN. I think it is a problem, not only in your State, Senator, but in many areas. There is disparity of payments not only to hospitals in different areas, but also the physicians in different areas and even in different specialties.

I think there have been some alterations in the situation whereby a new wage index has been developed. I'm not up to date on what specifically it does, but I am aware there is more part-time help in the rural hospitals, which does make some difference. The rural hospitals that are located close to the cities are hampered more than those farther out.

Some of the rural hospitals have been designated, I believe, as referral centers, which has also helped; but this still does not alleviate the entire problem. All I can do is assure you that we shall look at it and do our best to come up with a more equitable solution. There is a study going on now, as to whether such a classification is necessary or not.

Senator NICKLES. I appreciate that.

Has the President submitted a name for a replacement for Carolyn Davis, for HCFA?

Dr. BOWEN. No, not yet.

Senator NICKLES. I would urge that that position be filled as rapidly as possible because there's a lot of these types of issues that are on your plates. I know you have several vacancies, but I consider that one of the key vacancies that really needs to be filled.

Dr. BOWEN. Well, Senator, I have not talked about personnel simply because I thought it might be presumptuous.

Senator NICKLES. I understand.

You commented on it; I mentioned the DRGs as they relate to hospitals. You mentioned physicians. In my State, we have five different physician reimbursement areas, I guess, that have really caused some real inequities.

Again, I mention the hospitals, that's one case, and their bases, and I think we need some adjustments there. Our neighbor State of Arkansas has one physician rate. Our Oklahoma Medical Association, our State legislature, others have requested repeatedly of HCFA to have a single reimbursement rate, statewide: A unified rate, statewide.

I would echo that. We have been working with HCFA trying to get a pilot 1-year test of that proposal. I bring you up to date on the fact that that's very important to us.

We've got unified support, bipartisan support, really, through the medical community to do that and I hope that we'll be able to move forward rapidly with this study, the pilot program, if that works, then we could implement it in the following year.

Again, I just wanted to bring you up to date on that fact.

Just to give you an example, we have a physician in El Reno, which is 20 miles outside of Oklahoma City. He has an office in El Reno and has one in Oklahoma City, and he splits his office time. He's reimbursed $18 in Oklahoma City; he's reimbursed a million children needing home health care who are now institutionalized in part of some dank building. Additionally, there are over 10 million disabled adults who need home health care.

Finally, and most disturbing, there are over 5 million older Americans who are forced to live simply without any health care at all. These individuals, today, should not be in this position. We should make, to my mind, that deal with Medicare, the deductible and the reimbursement question. He mentioned the deductible going up from $492. I personally, likewise, feel that that's a significant 1-year, one-time increase is somewhat burdensome.

It seems to me as a person who has been in the private sector and a provider of health care, and one that's purchased health and accident insurance, one of the things that the private sector has done is, in some cases, maybe, a deductible not nearly that high, but some cost-sharing over that period of time.

Would you think that that would make sense, maybe, to have a lower deductible, not have it be $492, bingo, you get saddled with that whether in 1 day or whether in 60 days: have a much lower deductible and then have maybe some type of a cost-share, make it come out equal to where the patients would not really end up out-of-pocket costs altogether anymore, but maybe make it a little more balanced so it wouldn't be basically that hard of a hit up front and then Uncle Sam picking up the expense from the second day to the 60th day?

The CHAIRMAN. Senator, with that your time is up; but let's answer that question.

Dr. BOWEN. It, indeed, seems like a hefty increase and obviously I had nothing to do with the development of the formula or the establishment of this.

All I can say, again, is that I will look into it and see if the formula might need to be changed or if there is some way where you could make it a little less harsh on the individual.

Senator NICKLES. I appreciate your comment. Thank you.

The CHAIRMAN. Thank you, Senator Nickles.

Senator Dodd.

Senator DODD. Thank you, Mr. Chairman.

Doctor, we welcome you to the committee. Congratulations once again on your nomination. I had the pleasure of sitting with you a few weeks back. You came around to meet, I presume, all of us here on the committee, to get to know one another.

I raised a couple of questions with you then. I'd like to raise them with you again here this afternoon if I could. I don't know whether you're prepared. I don't expect you to be necessarily prepared to give me definitive answers today, but I would hope that we might be able to get some sooner than not.

Before getting into this, I would be just curious—this may have been asked of you already, but if it has not been, I wonder if you might respond—the report of the AMA that came out the other day has taken a rather strong position with regard to advertising of smoking, vending machines: a rather broad, sweeping, strong position.

Would you tell us what your views are with regard to AMA's position? Do you share those views?

Dr. BOWEN. It was brought up just a little bit ago and I'll try to summarize what I said. I do believe that smoking or use of tobacco is a health hazard. I also believe that the warning should be plainly on the label of products, and also that one should not ignore the views of the nearly 500,000 physicians stating that it is a hazard.

The whole area of advertising, the health hazard, and the effects of advertising on the increased use of smoking, especially on the younger people, needs to be studied; but, also, the right of the individual to choose should be considered.

If a person has been made aware of the hazards and the dangers, then perhaps the person should have a right to say, I understand that, but I want to do it anyhow.

Now, as a physician, I don't think he ought to; but as one who believes in a little more freedom, he ought to have the right to choose.

Senator DODD. What about the advertising? I understand choice, but do you believe there ought to be a ban on advertising?

Dr. BOWEN. I don't think I am prepared to say absolutely yes or no on that. I believe there should be a study to determine the effects of advertising on increased use, and then derive a judgment from that.

Senator DODD. And if it were able to be shown that there were some linkage, you might take it into consideration?

Dr. BOWEN. I think if there were a high linkage and it showed that a great many young people were influenced by it, I would personally lean toward the use of banning. But, again, that would be dependent upon the study.

Senator DODD. I understand. That was not one of the subjects that you and I talked about that day we got together.

Dr. BOWEN. No.

Senator DODD. One subject we did bring up is last summer the Congress appropriated $5 million—which does not sound like much, I suppose, but in the climate we have been in it was a rather substantial decision—to support a child abuse prevention Federal challenge grant act.

We all know, on this committee, how difficult it is to get something authorized, let alone something appropriated.

The CHAIRMAN. I think we have done pretty well this year so far.

Senator DODD. As you recall, I may have told you that the grant program worked for the $1 Federal matching fund for every $3 that the States would collect, specifically for child abuse prevention programs.

As a result, prior to the decision by the Congress and the decision by the President to sign that legislation of which it was a part, some 15 States had matching grant programs. Since the enactment of that legislation, 15 additional States have established by State statute their child abuse prevention programs in compliance or trying to comply with it, which would make them qualify for the Federal assistance.

So now with over 30 States that are prepared to move ahead with this kind of a program, the difficulty has been that we've had no regulations issued by the Department of Health and Human Services.

In fact, in a piece of correspondence from Dorcus Hardy, the indication was that—not the indication; I don't want to suggest to you here that it's a definition position, but the implication was that rather than issue regulations for this specific program they be rolling something along these lines into a block grant which could end up having an entirely different effect on the legislative intent.

It's only a 5-year program. We've already lost a year on this. I would like to know as soon as possible whether or not the Department will issue those regulations; if they are going to, when they would issue them. If they are not going to issue them, then I'd like to know why because it would appear to me that that would be, as I say, in direct contradiction to the decision by the Congress and the President.

Dr. BOWEN. Senator, by nature I am a punctual individual, and I assure you I shall see that we get our rules and regulations out as promptly as possible.

Senator DODD. I appreciate that.

Dr. BOWEN. I would give you that assurance.

Senator DODD. The indication has been that it's not a question of we'll get it done sooner or later. The feeling I have is that we're not going to do it at all.

Dr. BOWEN. Well, if its the direction from the Congress and the President, then I feel that it is a must that it be done.

Senator DODD. Well, I appreciate that. I thank you for that response as well.

This relates, as well, to the children's issues. For years, the Department of Health and Human Services and its predecessor, HEW, has been really one of the few private or public institutions that was really involved in children's issues in general. In recent years, we've seen a lot more activity by primarily private groups as well as States, cities, and the like.

However, in the past the Children's Bureau and the National Center on Child Abuse and Neglect were very high profile organizations and groups. This isn't this particular Senator's assessment, but the assessment of many. Lately, they have really taken a back seat, seem to have lowered their profile considerably at a time when there is heightened interest to what happens to the one out of every three Americans as a child.

I am curious as to whether or not you have had a chance to take a look at that particular situation I raised with you before. If you have, what is your assessment of it. How important do you perceive those two particular organizations are? Would it be your intention to try and raise the level of profile of those two organizations within the Department of HHS?

Dr. BOWEN. There is no group in the country more important than our children, and I certainly recognize that and would do all I could to promote whatever is necessary to improve their lot. I would have to admit to you, Senator, that since I have seen you I have been in briefing after briefing, and have received facts and materials so high that I cannot say that I have read and reviewed all of those.

But I would be glad to work with you and talk with you later, sir.

Senator DODD. I would appreciate that. Thank you.

Lastly—this is somewhat parochial, but I'm not alone in this—teaching hospitals have unique financial problems because of the patients, the level of the income that so many of the patients involved in teaching institutions have. As a result, of course, they have unique financial burdens.

There are obviously a number of these institutions around the country. I wonder if you might just comment briefly here for us today what thoughts you have with regard to any special treatment for these institutions because not only because of the income level of the patients they serve, but also because of their unique contribution to research and medical care generally.

I realize this is not a subject I expect you to go into in detail today, but there is great concern about how these institutions are going to remain financially afloat. I'm speaking, obviously, in our case of Connecticut Yale-New Haven Hospital. That is the one that causes the parochial interest.

But, as I say, there are institutions all across the country that fall into that category. The problems that Yale-New Haven faces are not unique. They are felt by teaching hospitals from one end of this country to the other.

Dr. BOWEN. I have been in a teaching hospital the last 5 years, so I am aware of the problem. The expenses are greater, simply due to the fact that they are teaching hospitals. Teaching hospitals, I think, have sicker patients and sometimes poorer patients, and they do research.

They also train the future specialists, the residents in training, and that also adds considerable expense. There have been those who say that you should remove the cost of the training of these individuals.

If that were done, it would actually increase the cost of the institutions, rather than decrease it simply because these residents in training do a great deal of the work and they would have to be replaced by individuals of higher salary. I am aware of the special problems of the teaching hospitals and there does have to be some added factor into the DRG Program to take care of it.

I am not prepared to say how much or what, but I am aware of it and will work with it.

The CHAIRMAN. Senator Dodd, your time has expired.

Senator DODD. Let me just make a last point. It really isn't a question, just to bring your attention to it if I could.

The CHAIRMAN. Sure.

Senator DODD. Governor Riley of South Carolina has headed up a task force on infant mortality in the South of this country. Governor Brennan of Maine did a study in his own State and across the country involving poor children's infant mortality.

They are both very disturbing studies with conclusions done in two regions of the country. Infant mortality is something we have been pretty successful in fighting over the last 20 years. In the last 4 of 5, any progress is frozen: it just hasn't moved at all.

These studies point them up and I would just draw your attention to them, and would hope that at some point with that stack of reading that you have to do you might slip a couple of these in to take a look at. I think you would find them most compelling.

Dr. BOWEN. I have already had correspondence from Governor Riley on that. So he has drawn it to my attention. I appreciate your mentioning it.

Senator DODD. Thank you, Doctor.

The CHAIRMAN. Thank you, Senator Dodd.

We'll turn to Senator Pell at this point.

Senator PELL. Thank you, Mr. Chairman. I congratulate you, Mr. Chairman, on scheduling this hearing as promptly as you have.

I know I have met briefly with Dr. Bowen and looked at his credentials pretty carefully, and think that he is extremely well-qualified. His is an excellent nomination. I think the most we can ask of a nominee is that his achievements as Secretary mirror his past successful political and medical accomplishments.

There is one concern I would like to emphasize particularly this afternoon, and that is the question of home health care. Here, I believe, we should do all we can to encourage the use of home health care.

We all know the statistics; we all know that there are approximately 10 million children needing home health care who are now institutionalized in part of some dank building. Additionally, there are over 10 million disabled adults who need home health care.

Finally, and most disturbing, there are over 5 million older Americans who are forced to live simply without any health care at all. These individuals, today, should not be in this position. We should make, to my mind, home health care readily available so there is no longer a reason to remove individuals from their home during a time of illness or, more particularly, as they approach death.

People should, I think, be more able and have the opportunity to die at home, and not—as now seems to be increasingly the custom—the hospital is a place where you go to die. In this regard, my own thought or reaction is that this administration has not done as much as it should in developing home health care.

In this regard, I would be very interested in the reaction of Dr. Bowen.

Dr. BOWEN. Senator Pell, home health care is really the fastest-growing part of the Medicare system. I realize you spoke of children and so forth, too——

Senator PELL. That's right.

Dr. BOWEN [continuing]. And I think that we need to do everything that we can to encourage and coordinate home health care with all groups.

It is a good follow-up to the DRG, system because it is less expensive than additional days in the hospital. It does have the potential of improving the quality of care and certainly improving the attitude of the individual who has to have this care; but I think it will require rather careful monitoring so that there isn't abuse or overutilization. We need to be careful about the quality, too, and monitor that.

Senator PELL. I believe I am correct in saying there is a growing amount of literature that supports the proposition that home health care is more effective from the viewpoint of delivery and cheaper.

Is this correct in your view? Is home health care the most cost-effective kind, more so than a hospital?

Dr. BOWEN. Well, I think there is no question that it is cheaper if it is not abused, and if it is not used as sort of an add on, to so speak, to all of the other potential programs. Will it be overutilized?

I'm for it and I think it is a good thing.

Senator PELL. In this regard, I would like to enter into the record a letter from Dr. Charles Kahn enclosing a memorandum on this subject. I would ask that it be received for the record.

The CHAIRMAN. Without objection, it will be.

Senator PELL. What this letter does is to verify that Medicare will no longer reimburse the home health care agency worker for the predrawing of the insulin syringes for diabetic patients. Since most of these patients are unable, themselves, to draw their own syringes on a daily basis, I raise this situation as a specific example and would hope that it's a point that you could look into in your new responsibility.

Dr. BOWEN. OK. Thank you. We shall.

Senator PELL. I would also like to get a reaction from you.

Would you agree, in principle, that the syringes cannot be administered very often by the patients themselves?

Dr. BOWEN. If the patient is crippled to the point that he cannot fill a syringe or if he is mentally incompetent, yes. Someone else would have to do that for him.

Senator PELL. I also have a couple of questions I would like to enter into the record.

The CHAIRMAN. Without objection, so entered.

Thank you, Senator.

Senator PELL. I wish you well and look forward to supporting your nomination.

Dr. BOWEN. Thank you, Senator.

The CHAIRMAN. Thank you, Senator.

Dr. Bowen, we are going to give you a 5-minute recess if you need that.

We will take a 5-minute recess and return promptly a little bit after 4:30.

Dr. BOWEN. Thank you.

[A brief recess was taken.]

The CHAIRMAN. If we can have order. We're happy to have Senator Kennedy back. He is going to resume his questions.

Senator KENNEDY. Thank you very much, Mr. Chairman.

The CHAIRMAN. Then we will have a few questions from Senator Kennedy and I believe that will wrap this up. Senator Kennedy.

Senator KENNEDY. If we could focus on the Medicaid Program and also the administration of that program in your State while you were Governor.

Now, I understand that there were sone seven reported cases in which your Director of Welfare, Wayne Stanton—now Regional Administrator of the Department of HHS—was found guilty of administering State welfare and Medicaid policies that violated Federal law and statute.

I suppose the question is do you intend to tolerate State noncompliance with Federal laws as Secretary of HHS?

Dr. BOWEN. No, we certainly will not tolerate noncompliance. There has to be a good explanation if there is any reason for noncompliance.

Senator KENNEDY. I apologize to the witness. What was your response, Doctor?

Dr. BOWEN. I say, I would not tolerate noncompliance. Obviously, I would want to listen carefully to the reasons why there was noncompliance and then make further judgment after hearing the response from the States that did not comply.

Senator KENNEDY. Well, whether there really is compliance or there is not compliance is what I gather from your answer. You want to make sure that you make a judgment whether there is compliance or noncompliance, and then if there's a judgment made that there is noncompliance you are not going to tolerate it. Is that correct?

Dr. BOWEN. That's right. Sure.

Senator KENNEDY. The one case that was particularly disturbing was the *Bond* v. *Stanton* in which the courts, all the way up to the

Supreme Court, held that the State was violating the Medicaid statute "* * * by failing to provide early and periodic screening, detection and treatment for poor children."

The court of appeals not only found the State in violation, but awarded fees to the plaintiffs' attorneys because the fees were justified by the "* * * bad faith of the defendants both in their conduct which necessitated the action and their conduct during the action." That's a direct quote.

Despite repeated losses in court, the State did not come into compliance until the administration of your successor. Is there anything you want to say about that particular case, whether it is a reflection of your own view about the need for this kind of medical treatment for poor children?

Dr. BOWEN. No, I don't think I have any statement.

Mr. Stanton was a very industrious and frugal administrator and did a good job. The courts found us wrong in this situation, so it was eventually righted.

Senator KENNEDY. But he was within your administration, as I pointed out, through a series of court decisions and it was never remedied.

Did you ever know about that when you were Governor? Did you ever know about these court cases?

Dr. BOWEN. That has been a good many years ago and I do not recall the specifics of it, sir.

Senator KENNEDY. Well, not the specifics; but, I mean, did you know that there were cases that were brought and that your administrator was found in violation of the Federal statute, and that it was necessary for the State of Indiana to pay attorneys' fees because of the fact that a court said "* * * by the bad faith of the defendants both in their conduct which necessitated the action and their conduct during the action * * *" by a court of appeals in your own State?

I am not asking about the details, but you must remember that that type of decision was made.

Dr. BOWEN. I recall that the decision was made, yes.

Senator KENNEDY. Well, were you concerned about it or not. I am trying to get some indication on this. You were evidently supporting, and you still do support your administrator there, Wayne Stanton.

Or did you find that he did this; you are a busy Governor; when it was brought to your attention it really bothered you, that the State of Indiana was failing to comply with those statutes; and when a circuit court judge said that "* * * by the bad faith of the defendants * * *", which meant the State, "* * * both in their conduct which necessitated the action and their conduct during the action * * *" warranted that, whether that bothered you since it involved poor children; poor children that don't have a lot of——

Dr. BOWEN. Senator, I do not recall the specifics of the case. I recall that there was such a thing that occurred and it was corrected.

Senator KENNEDY. But not during your administration, I understand.

Dr. BOWEN. I do not recall that.

Senator KENNEDY. That is, at least, my information. I will give you a chance, if you want to, to correct the record.

Dr. BOWEN. I can find out the details of it and let you know if you want.

[Information subsequently supplied for the record follows:]

Senator Kennedy

BOND v. STANTON

QUESTION:

With regard to Bond v. Stanton, I would like to make a few comments.

ANSWER:

The case was filed over eleven years ago and effectively ended over nine years ago, and I have no specific recollection of it. I am advised that the case involved a dispute over Indiana's compliance with regulations pertaining to its Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT Program). The District Court approved Indiana's plan on August 6, 1976. After taking two years to resolve the substantive issues of this case, the attorneys spent at least four more years arguing about their fees.

Although I regret that it took two years to resolve this matter, the District court was satisfied with Indiana's performance well before my first term as Governor was completed.

Senator KENNEDY. Sure. Fine.

Dr. BOWEN. I do not recall.

Senator KENNEDY. But if it was done within your administration, the record ought to reflect that. If it is not, then I think my earlier statement stands.

Dr. BOWEN. All right.

Senator KENNEDY. There has been the recent study by the Robert Wood Johnson Foundation that found that 1 million Americans annually are denied health care because they cannot pay for it, another 5 million did not even seek health care because they know they cannot afford it.

I am just wondering what your reaction is to that kind of circumstance in our country. How do you react, now, as somebody who is going to be taking on the position of HHS?

Dr. BOWEN. I do not think that adequate health care should be denied anyone. I am unfamiliar with the report.

Senator KENNEDY. Let's just take the fact, or at least take my statement that there are numbers of Robert Wood Johnson Foundation reports that found that 1 million annually are denied health care because they cannot afford it and 5 million do not seek it because they cannot afford it.

Would you be surprised if that was the case in America today?

Dr. BOWEN. We have, in my judgment, a great many programs. It is a matter of judgment whether it is enough or not, but there are programs that would be able to deal with the situation that you are talking about.

I think that it would be the duty of the Department to educate and enroll these people in the programs that do exist. If we find that inadequate, then we need to restudy the program and find out what needs to be done to correct it.

Senator KENNEDY. Well, you are familiar that many of these programs have been evaluated and found to be effective, but there is a continuing lack of commitment to them and a continuing reduction in the funding for these programs.

That does not come as any surprise to you, does it?

Dr. BOWEN. No.

Senator KENNEDY. Good programs that reach out and reach needy people in our society that are being reduced. I mean, that is not saying anything profound at this hearing, and you would certainly understand that to be the case, wouldn't you?

The WIC Program, for example.

Dr. BOWEN. Senator, as a physician, I just could not agree with you more that the Department of Health and Human Services should take every available opportunity to foster the health and well being of our country's children.

Now, HHS has some 14 key programs with an impact on children, and I can read them off to you but I guess you know them as well as anyone else. With these 14 key programs it seems to me that everyone ought to fit within one of them; and, if they don't, we need to try to enlist them.

Senator KENNEDY. What if they fit in them and there are not adequate resources to do it? What are you going to recommend?

Dr. BOWEN. Well, we, as I say——

Senator KENNEDY. You know the WIC Program, Doctor. You must know the impact that that has on expectant mothers; and you know that there is only a third of those that are eligible for the program who are getting it. We are seeing continued attempts to reduce that program.

That program, in terms of any evaluation, shows that it is saving dollars, first of all. Let's take away the questions in terms of meeting the human need: it is saving dollars down the road on it, and those tests have been done.

I would just would like to get some sense of whether the person that is going to be the Secretary of HHS is going to be an advocate for the needs of millions of people whose health is being impaired because of the failure of getting some of the very basic and fundamental support in terms of our society, and whether we are going to have an advocate for those people or not.

I am just giving you an opportunity to indicate whether you will or you will not. I think you have the votes, clearly, to get the job done; but I would like to give some opportunity for those people that look to the Secretary of HHS and know the importance and the power of that position.

I don't question that it is an enormous kind of a bureaucracy and incredibly difficult to administer. I give you all that.

But the question is whether they have someone in there who really knows that these problems exist in the society and is concerned about these problems, who is going to do the best that they can. Obviously, we are living in a climate of short resources, all of us. I am not being unrealistic about it.

But the question is whether there is going to be somebody who is going to be battling in there at those cabinet meetings and saying, this is what is happening to our future: that one out of four children in our country today is living in poverty and the numbers are

escalating, we are getting explosions in functional literacy, we are 49th in 152 countries in terms of literacy in the world—the United States is.

Whether we are talking about the numbers of children or what is happening in terms of education, that at that cabinet meeting there is going to be someone that is the Secretary of HHS who is going to say, "This is what is happening in this country to our people, and these are the things that can be done in our Department if we get the resources to do them."

I am just giving you an opportunity. I mean, I don't know whether you want it or not.

Dr. BOWEN. Senator, I appreciate the opportunity and I will do it in two statements.

Sure, I will be an advocate for the health and welfare of all the people of this country; and I will administer the laws that permit me to be that advocate as best I can and with the money that's made available to me by Congress and the administration.

Senator KENNEDY. I don't know, Mr. Chairman, if Dr. Bowen's been asked about the AIDS research or not.

The CHAIRMAN. He has not, thus far.

Senator KENNEDY. He has not.

We had, earlier this year, the Secretary of HHS proclaim the Acquired Immune Deficiency Syndrome as the No. 1 health problem confronting the Nation.

Is there anything that you want to say about the nature of this problem in our society?

Dr. BOWEN. Yes.

Senator KENNEDY. You are probably aware that there has been significant increase in terms of appropriations for research——

Dr. BOWEN. Yes.

Senator KENNEDY [continuing]. But I am interested, as a physician, in your own kind of assessment about how much of a problem this is.

Dr. BOWEN. I think it is one of the most important problems that faces this country simply because it is scary to the people.

Senator KENNEDY. And deathly to the people, too.

Dr. BOWEN. Well, 100 percent, eventually, unless we do continue with as much research as we possibly can, not only as to cause but as to treatment.

But I think I should pay tribute to NIH and all those who have been in the Centers for Disease Control who have been working on the problem for the last 4 or 5 years. It is just a new disease and they have come a long way in trying to solve the problem.

They know the cause and they know the effects, and they are working feverishly to develop a vaccine and/or drugs which will ameliorate or cure the disease. Certainly, I think that they should have a pretty free hand in saying what they need to do the job to conquer the disease.

Senator KENNEDY. Well, I hope you will watch to insure that the moneys which are expended are well utilized. I am sure you have gathered already that there is enormous interest across the country, in the Congress, and there has been significant increase in the funding. I think it is important that that be utilized as effectively as possible.

Having your attention on that, I think, will be important.

I will take just one more area, Mr. Chairman. That is the area of community mental health.

We are expending enormous amounts of money—over $8 billion in the last probably 2 to 2½ years—for institutional care. We have seen a reduction in the number of those who are mentally ill out of institutions with the progress that has been made in health care, specifically in drugs and other types of treatment.

We are in a situation where we have failed to provide the community-based care which is so important for many of these individuals. As a result, you cannot go in a city of this country or a rural community of this country without being faced without, I think, being faced with the problem of the homeless and, in many instances, those that have been institutionalized.

I will just give you a little anecdote. I don't want to delay our Chair here, he has been very patient, but this is an important issue, the mental health issues, and I know he cares about them.

I was talking a weekend ago, over Thanksgiving, with my mother who wanted to go down to church in the evening after supper, and I said, well, the church was closed. She is 95 years young and she asked me how do I know it is closed?

So I said, well, I will go and check. I called up the priest and found out that it was closed. When he came by to visit her in the morning, I said I thought that actually the church stayed open until sometime in the early evening.

He said that almost each month during the winter they have to close it earlier and earlier. They close it now at 5:00. I said, 5:00 is awfully early.

He said, "Senator, if we closed it at 6:00, we would have 30 to 40 homeless people that would be sleeping under the pews, and we would have to take them out. As the winter goes on and it gets colder and colder, we have to close the churches down earlier and earlier."

Now, this is in Hyannis, MA. It is not in an inner-city area. They have a lot of problems in terms of housing, certainly, in the summer. It's less so in the winter, but still serious problems.

The problems that we are facing as a society in this area of mental health are, I think, significant. We have the leverage, because we provide in terms of the institutional care, the Federal money, as you know, almost half, and we can leverage the system in terms of community-based care, provide better care for our elderly, I believe, and also I think can do that in a way that can, perhaps, insure that the funding and the moneys are going to be spent a great deal more efficient, effectively; and I think there's probably a good chance of saving some resources as well.

I don't know whether there is any comment that you want to make just about the problem or your own kind of concern about the importance of community-based systems and whether you will take this issue on as something that you will devote some time and energy toward, or what.

Dr. BOWEN. It is an area that does need attention. It is a serious problem and it bears heavily on the local areas perhaps more than the Federal.

But since it is sort of universal, I think that HHS does need to take a great interest in it.

It's my understanding that there is a study going on at the present time. The report has not yet been released, and I certainly want to take a good look at that to see what can be accomplished to prevent these sad things from happening.

We do have programs available and we should make every effort to get these people into the types of welfare programs that are presently available.

Senator KENNEDY. Well, Dr. Bowen, I am sure the report will be interesting; but, you know, the fact is we have current legislation now to deal with this. This issue has been before the Congress for 12 years or more since we began to start reducing the support for institutions.

I am just very hopeful. It is an immediate problem. I think it is a matter that demands immediate attention. Hopefully, we will be able to work with you on it.

We have a bipartisan bill which I think is an important effort here in our committee. To have the administration's support for suggestions, recommendations, changes I would certainly more than welcome having an opportunity to sit down with your people.

But I would hope that it would be an area of priority and importance.

I want to thank you very much, Dr. Bowen. We look forward. I am sure you are going to be confirmed. As you well know, I think this is the agency of Government that best reflects our sense of humanity and decency.

I know that there are many who are quick to talk about all the money that is expended through that agency. I think there are a lot of things that are going on that are of enormous importance and consequence to our well being as a society and to what this society and our country is really all about.

So, I will look forward to working closely with you. I appreciate the Chair giving me a chance to raise at least some of these concerns.

As the Doctor knows and will find out there are a few opportunities that we have to be able to raise the matters that we feel strongly about, and raise them in terms of hopefully gathering some attention from the nominees. That is part of this process.

So, I thank you for your patience and your tolerance, and I thank the Chair. I will look forward to working with you in the future.

I thank the Chair.

The CHAIRMAN. Thank you, Senator Kennedy.

I want to thank Senator Kennedy for having so much interest in this position and in this agency. I agree with him: It is a crucial agency in Government. It is a huge agency that does an awful lot of good for many people.

But even as big as it is with the third largest budget in the world as Senator Kennedy has aptly pointed out, there still isn't enough money to take care of every problem that people have in our country today. There are many people suffering, the ill and mentally disturbed, the handicapped, et cetera, for whom we have to find

better ways of making those dollars go farther in these tough budgetary times.

If there is a man who can do that, I am convinced you are he. You are the person.

I want you to know that I have listened today and I know that you are a person of compassion with regard to the rights and feelings of your fellow human beings. I feel honored to have you here.

I think the President has made an excellent choice. I look forward to working with you as well. This committee is the largest authorizing committee in the Congress and we have a high number of programs that shift from time to time.

I want to compliment my friend, Senator Kennedy, for the time and effort he has spent here to advance his point of view. Many of his points of view are law today.

Since I have been chairman we have passed many bills through the Congress out of this committee. Any time I have asked for help from Senator Kennedy, he has tried to help me; and I appreciate it.

I think you will find that if you ask for help, he will try to help you as well, even though from time to time we differ.

So, I just want to express my appreciation to all of the committee members. We have had quite a few show up today in an afternoon that is extremely heavy with all kinds of conferences and with all kinds of controversies, right at the end of the session.

I think it's a tribute to you and to the importance of the issues that you have to deal with. Frankly, I think you have acquitted yourself rather well.

So, with that, we look forward to seeing you confirmed as Secretary of Health and Human Services. We wish you the very best. We are grateful to have your wife with us. And we hope this has been, if not a pleasant experience, at least one that you have enjoyed and have learned from.

I believe it has been a basically pleasant experience.

Thank you so much.

We have a question from Senator Stafford and a statement of Senator Grassley which, without objection, will be inserted in the record at this point.

[The prepared statement of Senator Grassley and the question referred to along with additional material supplied follow:]

SENATOR CHARLES E. GRASSLEY

MR. CHAIRMAN, I APPRECIATE THE OPPORTUNITY FOR GOVERNOR BOWEN TO APPEAR BEFORE THE LABOR AND HUMAN RESOURCES COMMITTEE THIS AFTERNOON. AS A MEMBER, AS WELL, OF THE SENATE FINANCE COMMITTEE, I PARTICIPATED IN THE CONFIRMATION HEARING THAT WE CONDUCTED IN THAT COMMITTEE YESTERDAY MORNING. I WAS PLEASED TO SEE THAT DR. BOWEN WAS UNANIMOUSLY APPROVED BY THE FINANCE COMMITTEE EARLIER TODAY, AND COMPLEMENT HIM FOR THE FINE JOB WHICH HE DID IN ADDRESSING THE CONCERNS OF THAT COMMITTEE.

DR. BOWEN BRINGS AN ABUNDANCE OF SKILLS TO THE POSITION FOR WHICH HE IS NOMINATED AS HEAD OF THE LARGEST AGENCY IN THE FEDERAL GOVERNMENT. AS A FORMER PRACTICING PHYSICIAN, SPEAKER OF THE INDIANA HOUSE OF REPRESENTATIVES, AND GOVERNOR, DR. BOWEN HAS DEMONSTRATED HIS ADMINISTRATIVE ABILITY AND COMMAND OF THE MYRIAD OF ISSUES WHICH HE WILL FACE TO IMPROVE THE HEALTH AND SOCIAL WELL-BEING OF OUR CITIZENRY. I AM PARTICULARLY PLEASED THAT GOVERNOR BOWEN COMES TO THE DEPARTMENT OF HEALTH AND HUMAN SERVICES WITH SUCH A STRONG BACKGROUND IN HEALTH POLICY, BECAUSE I FEEL THAT ONE CRITICAL

CHALLENGE CONFRONTING A NEW SECRETARY IS THE BALANCING OF CONTROLLING SPIRALING HEALTH CARE COSTS WHILE GUARANTEEING THE FINE QUALITY OF HEALTH CARE WE HAVE ENJOYED IN THIS NATION.

AGAIN, I CONGRATULATE GOVERNOR BOWEN ON HIS APPROVAL BY THE FINANCE COMMITTEE THIS MORNING AND HOPE THAT HE WILL BE SPEEDILY CONFIRMED BY THE FULL SENATE. THROUGH MY DISCUSSIONS WITH THIS DISTINGUISHED NOMINEE BOTH PRIVATELY AND THROUGH HIS OTHER PUBLIC HEARING, I AM CONFIDENT THAT HE IS AN EXCELLENT CHOICE TO TAKE ON THE FORMIDABLE TASK AS OUR NEW SECRETARY OF HEALTH AND HUMAN SERVICES.

QUESTION FROM SENATOR ROBERT T. STAFFORD

Governor Bowen I would like to bring your attention to a situation in the Department which is of concern to me and a number of other Senators. It involves the Rural Development Loan Fund (RDLF) which is administered by the Office of Community Services (OCS).

For 18 months non-profit organizations, which are intermediary borrowers of RDLF funds, have been negotiating with OCS to restructure the interest rates of the program. In August, officials from OCS and representatives of the intermediaries reached an agreement on the future of the program and it was sent on to the Department for final approval. We are still waiting for approval of the agreement.

I am concerned about the adverse impact that the delay in HHS approval is having on the program.

Would you look into this matter and report back to me on the status of the RDLF proposal and your Department's final action on it?

STATEMENT

of the

AMERICAN MEDICAL ASSOCIATION

to the

Committee on Finance and
Committee on Labor and Human Resources
United States Senate

RE: The Nomination of Otis R. Bowen, M.D. as
Secretary of Health and Human Services

December 6, 1985

The American Medical Association strongly supports the nomination of Otis R. Bowen, M.D., as Secretary of Health and Human Services.

The appointment of the first physician as Secretary of HHS could not come at a more opportune time. During this period of tremendous change in our health care delivery system and serious federal budgetary pressures, it is vitally important that the HHS Secretary have a clear understanding of our nations's health needs and a proven record of effective management. President Reagan said it best when he stated that Dr. Bowen was selected because of "all the qualifications that he had in excess for this particular position."

Dr. Bowen's experience as a family physician, medical professor, Speaker of the State House, and two-term Governor has provided him with extensive experience to direct HHS. In addition, as chairman of the Advisory Council on Social Security, Dr. Bowen has acquired detailed

knowledge of the Medicare program which is destined to be a major point of debate in future deficit reduction efforts.

The American Medical Association strongly supports efforts to provide health care in a cost-effective manner resulting in real reductions in health care expenditures. At the same time, we are committed to ensure that the quality of health care not be sacrificed to achieve short-term budget savings that may well lead to cost increases over the long run.

During the last five years, deficit reduction legislation has targeted the Medicare program for a disproportionate share of budget cuts. Medicare cannot sustain a continuous stream of multi-billion dollar budget cuts without impairing the quality of care provided to senior citizens and the disabled.

The appointment of Dr. Bowen will enable the Administration and Congress to benefit from the counsel of an individual who understands in human terms what effect future budget decisions will have on the health and welfare of American citizens. We are confident that such practical insight will prove to be invaluable to both branches of government in the difficult process of establishing budget priorities.

For nearly one hundred years, the American Medical Association has advocated the creation of a separate cabinet-level federal Department of Health headed by a physician. While the issue has not been actively considered by Congress in recent years, it is more important than ever before that health issues receive the degree of careful attention of a practicing physician such as Dr. Bowen.

We strongly urge prompt approval of Doctor Bowen's nomination.

The CHAIRMAN. With that, we will recess until further notice.
[At 5:02 p.m., the committee adjourned sine die.]

59-540 (96)